

## North Highland Vulnerable Pregnancy Pathway

Taking a trauma informed approach in understanding and responding to vulnerability in pregnancy

Maternity Services  
NHS North Highland / Highland  
Council Care and Learning

Warning – Document uncontrolled when printed

<b>Policy e-library Reference No:</b>	<b>Date of Issue:</b> February 2021
<b>Prepared by:</b> Midwifery Development Officer Claire MacPhee	<b>Date of Review:</b> February 2024
<b>Lead Reviewer/Owner:</b> Claire MacPhee Midwifery Development Officer	<b>Version:</b> 2
<b>Ratified by:</b> MNSSCC HC Clinical Governance Group	<b>Date Ratified:</b> October 2020
<b>EQIA For Fairness:</b> Yes	<b>Date EQIA:</b> September 2020 <a href="http://intranet.nhsh.scot.nhs.uk/Staff/EqualityAndDiversity/EqualityImpactAssessment/Pages/Default.aspx">http://intranet.nhsh.scot.nhs.uk/Staff/EqualityAndDiversity/EqualityImpactAssessment/Pages/Default.aspx</a>

### For official Use:

#### Distribution

##### NHS North Highland

- Board Nurse Director
- Head of Midwifery
- Lead Midwives
- Midwives
- Lead Nurses
- Lead AHPs
- NMAHP Leadership Group
- Obstetricians
- Sexual Health Services
- GPs & GP sub group

##### Highland Council

- Head of Health
- Principal Officer Nursing
- Principal Officer AHPs
- Principal Officer Social Care
- Principal Officer Child Protection
- Child Protection Advisors
- Managers Children & Families
- Health Visitors/FNP
- School Nurses
- Youth Action Teams



Content		Page No
1.	Introduction	4
2.	Scope and Purpose	4
3.	Supervision	4
4.	Training	4
5.	North Highland Vulnerable Pregnancy Pathway	5
6.	North Highland VP Pathway Components	6-13
6.1	Highland Practice Model	6
6.2	Wellbeing Assessment (SHANARI)	6
6.3	Maternity Notes (badgernet)	7
6.4	Health Plan Indicator (HPI)	7
6.5	Chronology of Significant Events	7
6.6	Practice Lead for Care and Protection	7
6.7	Child Protection Advisor Health	8
6.8	Antenatal (A/N) Plan	8
6.9	Information Sharing Procedures	8
6.10	Risk of Significant Harm	9
6.11	Child Concern Form	10
6.12	Antenatal Plan Meeting	10
6.13	Partner Agencies	10
6.14	Pre-Birth Child Protection Planning Meeting (CPPM)	10
6.15	Escalation Process	11
6.16	Child Protection Register	11
6.17	Child Protection Order (CPO)	11
6.18	Named Person Role	11
6.19	Lead Professional Role	12
6.20	Core Group	12
6.21	Unborn Child's Protection Plan	13
6.22	Maternity Alert Form	13
6.23	Decision Letter	13
6.24	Review Meetings	13
7	Additional Support Services	14-15
8	Supporting Local Guidance	15
9	Supporting National Guidance	15
Appendix 1	Antenatal HPI Wellbeing Assessment	17-18
Appendix 2	Multi-Professional Single Agency Antenatal Plan	19-21

Warning – Document uncontrolled when printed

Policy Reference:	Date of Issue: February 2021
Prepared by: Claire MacPhee Midwifery Development Officer	Date of Review: February 2024
Lead Reviewer: Claire MacPhee Midwifery Development Officer	Version: 2
Ratified by:	Page 3 of 20

## 1. Introduction

The early identification of factors which may place an infant at risk, during pregnancy and/or the postnatal period is crucial for a proactive prevention strategy for the protection of vulnerable children. Ensuring that vulnerable families get the right help at the right time and early provision of safe, effective family centred care will ensure best outcomes for children.

Work with all families can be enhanced by taking a *Trauma Informed* approach by building **trusting** relationships based on **choice** and **collaboration** empowering families with a sense of **control** and **safety**.

## 2. Scope and Purpose

The purpose of this protocol is to ensure standardised timely and proportionate care is received by all vulnerable women and their families across North Highland. It aims to provide clear guidance for staff around roles and responsibilities and expected timescales for those who may need multi agency support. It should be used in combination with Highland Child Protection Guidelines and the Highland Practice Model supporting the framework of family centred care with the needs of the unborn/child at the centre.

This guidance was developed using both national and local guidance and best practice. Consultation was widely undertaken with relevant staff and all agencies involved with supporting vulnerable pregnant women in North Highland.

## 3. Supervision

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

## 4. Training

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

- [Highland Child Protection Committee Training Page](#) (New 2hr multidisciplinary vulnerable pregnancy online session now available)
- [Violence against Women Partnership Training Page](#)
- [Health Promotion/Health behaviour change](#)
- [NES essential Perinatal and infant Mental Health e-Learning](#) (7 PNIMH Modules on Turas: Introduction, assessment, stigma, interventions, pharmacological interventions, risk in the perinatal period and keeping baby in mind)
- [NES Infant Mental Health e-Learning](#)
- [Highland Practice Model Training](#) is now accessed as "Introduction to Child Protection" via CALA website a voucher is required from CP training team
- [Children affected by Parental Substance misuse](#), [What makes a good Chronology](#), [Introduction to child exploitation](#) e-learning modules are all free and accessible via CALA
- [NES national trauma training programme](#) a suite of training resources available on Turas covering informed, skilled and specialist
- [NES Protecting Children e-Learning](#) via Turas
- [Health Literacy Tools and Techniques](#)

## 5. North Highland Vulnerable Pregnancy Pathway

Warning – Document uncontrolled when printed	
Policy Reference:	Date of Issue: February 2021
Prepared by: Claire MacPhee Midwifery Development Officer	Date of Review: February 2024
Lead Reviewer: Claire MacPhee Midwifery Development Officer	Version: 2
Ratified by:	Page 4 of 20

North Highland Vulnerable Pregnancy Pathway

By 16 Weeks <b>Primary Midwife</b>	Carries out <a href="#">Wellbeing Assessment (SHANARI)</a> (see appendix 1) on ALL pregnant women, as per <a href="#">Highland Practice Model</a> and <a href="#">Electronic Maternity Notes (Badgernet)</a>	
	Allocate Health Plan Indicator <a href="#">Health Plan Indicator</a> as Core or Additional.	
	Commence single agency <a href="#">Chronology of Significant Events</a> if appropriate.	
	Refer to <a href="#">Additional Services</a> if appropriate, with consent.	
	If socially complex and the unborn baby is considered at risk of significant harm consider immediate discussion with Social Work (SW) via <a href="#">Practice Lead for Care and Protection (PL for C&amp;P)</a> and <a href="#">Child Protection Advisor Health (CPA)</a> . Any concern for older children within the household/family should also be considered and shared.	
By 22 weeks <b>if additional HPI and SW input required</b>	Commence single agency <a href="#">A/N Plan</a> with mother, copy to partners of the plan in line with <a href="#">information sharing procedures</a> .	
	Notify SW via PL for C&P if potential <a href="#">risk of significant harm</a> without delay by telephone followed up by <a href="#">Child Concern Form (CCF)</a> as soon as possible The <a href="#">A/N plan</a> should be shared also when completed.	
By 24 weeks	Primary midwife considers convening an <a href="#">Antenatal Plan Meeting</a> with parent/s and <a href="#">partner agencies</a> involved in the plan. The CPA (Health) is available to support this meeting.	
	Following shared assessment of risks and needs at the A/N Planning Meeting a decision is made to either continue with multi agency planning or proceed to <a href="#">Pre Birth (Initial) Child Protection Planning Meeting (CPPM)</a>	
	If <a href="#">Pre-birth CPPM</a> is required a Social Work lead professional will be appointed and coordinate the risk assessment.	
	Where interagency disagreement exists the <a href="#">escalation process</a> should be followed.	
24- 28weeks	If required a <a href="#">Pre-birth CPPM</a> should be coordinated and convened by SW to take place no later than 28 Weeks gestation. The meeting will gain either a unanimous or majority decision from professionals based on shared assessment and available information at this meeting to place unborn name on <a href="#">Child Protection Register</a> if deemed at risk of significant harm. If decision is made to register the unborn is made, any need for application of a <a href="#">Child Protection Order (CPO)</a> should form part of the discussion at this meeting and included on the Child Protection Plan. If CPO is to be sought at birth, a decision should be made regarding where the new born is taken after delivery. It should not be assumed that the baby will go to SCBU. Any need for supervision of the parents must be discussed and will be the responsibility of the Lead Professional to organise.	
	If the unborn babies name is placed on child protection register Social work will automatically assume the role of <a href="#">lead professional</a> and arrange <a href="#">core group</a> meetings as per child protection guidance. The <a href="#">unborn child's plan</a> is updated as agreed with parents and relevant professionals.	
	It is the Primary Midwife's responsibility to ensure the <a href="#">Maternity Alert Form</a> is completed at the initial CPPM and filed in the hospital maternal notes. Any plans for CPO, supervised contact or information relevant to Hospital Maternity Staff should be recorded on the Maternity Alert Form by the Primary midwife.	
	If unborn baby not deemed at risk of significant harm following Child Protection Planning Meeting the A/N plan is updated, the lead professional agreed and <a href="#">Review Meetings</a> arranged for around 4 weeks' time whilst continuing appropriate liaison with partners to plan.	
Post Birth	If unborn baby is placed on the Child Protection Register or has an Unborn Childs Plan a pre-discharge meeting <b>must</b> be considered. This is the role of the Lead Professional who will liaise with maternity staff and partners to the plan ensuring smooth transition to the community.	
	If a CPO is sought at birth and is served then the baby will be taken to a place of safety as agreed at CPPM, details of which will be available to hospital staff on the Child Protection Maternity Alert Form filed in the Hospital Notes.	
Late booker/ Concealed Pregnancy	If a woman presents after 20 weeks AND there is considered a potential risk of significant harm discussion with SW should not be delayed. A summary of concerns should be conveyed via the telephone and followed up with <a href="#">CCF</a> . Complete the A/N plan and share as soon as possible.	

## 6. North Highland VP Pathway Components

### 6.1 Highland Practice Model

Full guidance can be accessed [here](#)

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

**Highland Practice Model’s** has an integrated service delivery structure the main components being:

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

**The Five Questions:**

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

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

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

**The Antenatal Plan** identifies the actions necessary to address the mother’s needs to support her and her unborn baby. It assists practitioners to focus on analysis and outcomes within set timescales and with clear arrangements for monitoring and review.

**The Child’s Plan** records an assessment and all of the actions required to meet additional needs which are proportionate to the child’s circumstances. The Child’s Plan is achieved through collaboration with the family and child. The family and services around the child are called the partners to the plan. A core group of significant family members and professionals is identified, including the child if appropriate.

When the Child’s Plan can be fulfilled by some additional resources within a universal service, this is a **Single service Child’s Plan**. When the Child’s Plan requires the input of more than one service, this is a **Multidisciplinary Service Child’s Plan**. When interventions are required to protect a child from significant harm, this is a **Child’s Protection Plan**.

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

- Summarising needs in relation to well-being
- Agreeing goals and the steps required to reach these goals
- Constructing a plan and taking appropriate action
- Reviewing the plan

### 6.2 HPI Well Being Assessment (SHANARI) please click for guidance



Crib Sheet HPI Wellbeing shanari A

All pregnant women should have an HPI wellbeing assessment completed by around 16 weeks. If they are assessed by the midwife as *additional* a copy must be securely emailed to the named HV/FNP. This is an assessment which looks at the wider aspects of wellbeing that contribute to a healthy mother and baby. Both

<b>Warning – Document uncontrolled when printed</b>	
<b>Policy Reference:</b>	<b>Date of Issue: February 2021</b>
<b>Prepared by: Claire MacPhee Midwifery Development Officer</b>	<b>Date of Review: February 2024</b>
<b>Lead Reviewer: Claire MacPhee Midwifery Development Officer</b>	<b>Version: 2</b>
<b>Ratified by:</b>	<b>Page 6 of 20</b>

strength and pressures are identified assisting in early allocation of help when needed and strengthening self-efficacy and resilience. The 7 wellbeing indicators **Safe, Healthy, Achieving, Nurtured, Active, Respected and Included**, see appendix 1 for helpful crib sheet to aid assessment. This assessment can be used as a request for service within health and will aid further analysis and completion of the A/N plan should assistance be required from Social Work.

### 6.3 Electronic Maternity Notes (Badgernet)

Badgernet is the electronic notes system developed by Clevermed hosted on Microsoft's azure platform which allows healthcare professionals to record and view on in real-time at the point of care both in the community and acute settings.

Women can also view their notes using a pc/tablet or smartphone and access leaflets recommended by their by midwife.

Some paperwork still currently requires to be scanned into BN,

- The HPI wellbeing assessment
- The A/N Plan
- The maternity Alert forms
- Child concern forms

It is important that they are named and dated to ensure the correct version is quickly found at point of care. Work is ongoing with Clevermed to reduce and eliminate the need to add these paper documents.

There are several SOPs and guidance on how to use the social pathway on NHS Badgernet intranet site contained within the Social Folder [here](#)

### 6.4 HPI (Health Plan Indicator)

The HPI indicates the level of service required by the woman/family/child and is assessed as core or additional. The health visitor/public health nurse is responsible for allocation of the HPI. The maternity team can assist in this process by ensuring early communication and care planning for those families with complexity or identified vulnerabilities. The allocation of the HPI requires a structured approach to assessment, this approach ties in with the appropriate, proportionate and timely interventions approach. Any information around allocation of the HPI should be shared with HV/FNP/PHN. The following are **examples** of HPI allocation:

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

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

### 6.5 Chronology of Significant Events

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

Warning – Document uncontrolled when printed	
Policy Reference:	Date of Issue: February 2021
Prepared by: Claire MacPhee Midwifery Development Officer	Date of Review: February 2024
Lead Reviewer: Claire MacPhee Midwifery Development Officer	Version: 2
Ratified by:	Page 7 of 20

shared with all relevant persons, in accordance with applicable legislation and agencies’ information sharing guidance and protocol.

A more comprehensive guide by the care inspectorate updated 2017 which includes good practice examples is available [here](#)

## 6.6 Practice Lead for Care and Protection

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

Contact details for Practice lead’s for care and protection across North Highland can be found [here](#)

## 6.7 Child Protection Advisor Health

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

- Advise on referrals to social work, record keeping, training relevant to post, HCPC Guidelines
- Take part in multi-agency discussions regarding health information, interpretation and assessment of children with Child Protection concerns.
- Ensure appropriate attendance at Child Protection Plan Meeting, and other relevant meetings.
- Assist with providing information and preparing reports for child’s plans as appropriate for the purpose of assessment and investigations
- Facilitate transfer in/out of records where children are of concern or on Child Protection Register.
- Initiate and disseminate and follow up Missing Family Alerts.
- Support through legal processes and in consultation with the Central Legal Office as appropriate.
- Supervise practice, and peer review as appropriate.
- Undertake case reviews and Quality Assurance.

Contact details for Child Protection Advisors across North Highland can be found [here](#)

## 6.8 Antenatal (A/N) Plan

A crib sheet guidance on completing the A/N plan:



crib sheet AN plan  
V3 010321.doc

The A/N Plan is an assessment (my world triangle) and should be used as a request for service input from colleagues (predominately social work) out with health. It encompasses the following components:

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

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

<b>Warning – Document uncontrolled when printed</b>	
<b>Policy Reference:</b>	<b>Date of Issue: February 2021</b>
<b>Prepared by: Claire MacPhee Midwifery Development Officer</b>	<b>Date of Review: February 2024</b>
<b>Lead Reviewer: Claire MacPhee Midwifery Development Officer</b>	<b>Version: 2</b>
<b>Ratified by:</b>	<b>Page 8 of 20</b>



## 6.9 Information Sharing Procedures

Healthcare staff have a duty to share information when an unborn baby, child or young person may be at risk of significant harm. This will always override a professional or agency requirement to keep information confidential. Information should be disclosed only for the purpose of protecting children and young people and therefore should be relevant and proportionate and shared promptly and effectively when necessary. Staff should seek advice if they are not confident about sharing information from their local Child Protection Advisor. Highland Data Sharing Partnership guidance can be accessed [here](#):

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

## 6.10 Risk of Significant Harm

Significant harm is a complex matter, subject to professional judgement based on multiagency assessment of the circumstances of the child and their family. **Professional judgement**, substantiated by the assessment of individual cases or by research evidence, is that the child is likely to suffer ill-treatment or the impairment of health or development as a result of physical, emotional, or sexual abuse or neglect.

Significant harm is **not** of a minor, transient or superficial nature. It can result from a specific incident, a series of incidents or an accumulation of concerns over a period of time. It is essential to consider the impact (or potential impact) on the child takes priority and not simply the alleged abusive behaviour.

**Harm** means the ill treatment or the impairment of the health or development of the child, including, for example, impairment suffered because of seeing or hearing the ill treatment of another. In this context, "development" can mean physical, intellectual, emotional, social or behavioural development and "health" can mean physical or mental health. Whether the harm suffered, or likely to be suffered, by a child or young person is **significant** is determined by comparing the child's health and development with what might be reasonably expected of a similar child.

Warning – Document uncontrolled when printed	
Policy Reference:	Date of Issue: February 2021
Prepared by: Claire MacPhee Midwifery Development Officer	Date of Review: February 2024
Lead Reviewer: Claire MacPhee Midwifery Development Officer	Version: 2
Ratified by:	Page 9 of 20

There are no absolute criteria for judging what constitutes significant harm. In assessing the severity of ill treatment or future ill treatment, it may be important to take account of: the degree and extent of physical harm; the duration and frequency of abuse and neglect; the extent of premeditation; and the presence or degree of threat, coercion, sadism and bizarre or unusual elements. Sometimes, a single traumatic event may constitute significant harm, for example, a violent assault, suffocation or poisoning. More often, significant harm results from an accumulation of significant events, both acute and long-standing, that interrupt, change or damage the child's physical and psychological development.

To understand and identify significant harm, it is necessary to consider:

- The nature of harm, either through an act of commission or omission;
- The impact on the child's health and development, considering their age and stage of development;
- The child's development within the context of their family and wider environment;
- The context in which a harmful incident or behaviour occurred;
- Any particular needs, such as a medical condition, communication impairment or disability, that may affect the child's development, make them more vulnerable to harm or influence the level of care provided by the family;
- The capacity of parents or carers to meet adequately the child's needs; and
- The wider and environmental family context.

## 6.11 Child Concern Form

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

## 6.12 Antenatal Plan Meeting

The purpose of the Antenatal Planning meeting is to gather multiagency information in order to decide whether to proceed to a pre-birth child protection planning meeting.

## 6.13 Partner Agencies

Partner agencies include Highland Council, Police Scotland, NHS Highland, Third Sector Agencies

## 6.14 Pre-Birth (Initial) Child Protection Planning Meeting (CPPM)

The pre-birth CPCM should take place no later than at 28 weeks pregnancy or, in the case of late notification of pregnancy, as soon as possible from the concern being raised but always within 21 calendar days of the concern being raised. The purpose of a pre-birth CPCM is to decide whether serious professional concerns exist about the likelihood of harm through abuse or neglect of an unborn child when they are born. The participants need to prepare an inter-agency plan in advance of the child's birth. They will also need to consider actions that may be required at birth, including:

- whether it is safe for the child to go home at birth;
- whether there is a need to apply for a Child Protection Order at birth;
- whether supervised access is required between the parents and the child and
- who will provide this if needed;

Warning – Document uncontrolled when printed	
Policy Reference:	Date of Issue: February 2021
Prepared by: Claire MacPhee Midwifery Development Officer	Date of Review: February 2024
Lead Reviewer: Claire MacPhee Midwifery Development Officer	Version: 2
Ratified by:	Page 10 of 20

- whether the child’s name should be placed on the Child Protection Register. It should be noted that as the Register is not regulated by statute, an unborn child can be placed on the Register. Where an unborn child is felt to require a Child Protection Plan, their name should be placed on the Register;
- Whether there should be a discharge meeting and a handover to community-based supports.
- There may be exceptions to this where the pregnancy is in the very early stages. However, concerns may still be sufficient to warrant an inter-agency assessment.

## 6.15 Escalation Process

Any professional who contests the planning and decision making in any plan and believes that a child or family is not being supported in line with the Highland Practice Model and Child Protection Guidelines, has a responsibility to escalate this matter.

In the first instance, escalation should be to the Family Team District Manager, and then to the Area Children’s Services Manager and Area Care & Learning Manager. At any stage, the appropriate manager can instruct a review of the plan.

In serious cases, where there are a number of unresolved concerns, these should be escalated to the Head of Children’s Services or to ultimately the Director of Care & Learning for discussion with Chief Officers.

Children and families should be encouraged to raise unresolved concerns through the same means. Disagreement about a case decision would not, normally, be considered as part of complaints procedures.

## 6.16 Child Protection Register

The Child Protection Register provides a record of children who require a multi-agency plan to reduce the risk of significant harm. In Highland Council, this responsibility lies with the Care and Learning Service.

All partner agencies are encouraged to use the Register.

The Register has no legal status but provides a central point of enquiry for any professional staff who are concerned about a child. The Child Protection Register is maintained on the Council CareFirst management information system. The Resource Manager (Child Protection), who is the Keeper of the Register, has responsibility for the management of it.

Enquiries to the Register should be made to a local Family Team Practice Lead for Care and Protection or the Out-of-hours service, when a professional becomes aware of or is suspicious of child abuse and neglect. A call back system is used to verify the caller’s identity and location. All enquiries to the Register are recorded. The caller’s name, agency, time, date and reason for the enquiry are noted.

## 6.17 Child Protection Order (CPO)

This is an emergency measure which aims to protect children and young people who are at risk of significant harm and is applied for when there is an urgent need for protective action. It authorises the applicant to remove a child from circumstances in which he or she is at risk or retain him or her in a place of safety. The reasons for decisions to apply for the order should be clearly recorded. A child protection order may also specify conditions (e.g. medical examination) attached to the order.

## 6.18 Named Person Role

The Named Person is a point of contact for children, families and professionals for information sharing, advice and assistance, when required. The Named Person has an important role in coordinating additional help for children within universal services.

Whilst an unborn baby doesn’t have a named person until birth, the primary midwife will assume the named person *service* for a pregnant woman, working in partnership with the allocated Health Visitor.

<b>Warning – Document uncontrolled when printed</b>	
<b>Policy Reference:</b>	<b>Date of Issue: February 2021</b>
<b>Prepared by: Claire MacPhee Midwifery Development Officer</b>	<b>Date of Review: February 2024</b>
<b>Lead Reviewer: Claire MacPhee Midwifery Development Officer</b>	<b>Version: 2</b>
<b>Ratified by:</b>	<b>Page 11 of 20</b>

Health visitors are the named person from birth until the child enters education.

## 6.19 Lead Professional Role

The Lead Professional is the person who co-ordinates the assessment, actions and review of the Unborn/Child's Plan. The Lead Professional will not do all the work with the child and family. Neither does he or she replace other staff who have specific roles or who are carrying out direct work or specialist assessments. The choice of the role of Lead Professional for a particular child will be influenced by: the kind of help the child or family needs, complexity of the child's circumstances and plan, previous contact or a good relationship with the child statutory responsibilities to co-ordinate work with the child or family.

A Registered Social Worker will always be the lead professional for:

- Children including unborns who have multi-disciplinary child protection plans
- Looked after children
- Looked after and accommodated children

## 6.20 Core Group

The core group will be confirmed at the Child Protection Plan Meeting and will involve the:

Lead professional; Named Person Key professionals, directly involved with the child/ren and family, from health, care & learning, adult services, third sector, forces welfare, police, and housing services as appropriate; Where possible, parent/s and/or carer/s.

The Lead Professional or line manager will normally be responsible for chairing the core group, and ensuring it is recorded.

The record of core group meetings must be completed on the standard format. This should be signed by the Chair of the core group and the Practice Lead for Care and Protection.

The core group record should be distributed to child/ren, parent/s and carer/s, all professionals attending, and a copy should also be forwarded to the Practice Lead for Care and Protection, and Quality Assurance Reviewing Officer.

The first core group subsequent to the Child Protection Plan Meeting will take place within 14 calendar days of registration, but child protection activity and the progression of actions agreed in the child protection plan must begin immediately and not wait until after the core group is convened.

Core group members must:

- agree the detailed actions to be carried out to implement the child protection plan and ensure that risk will be reduced, and the wellbeing of the child promoted;
- agree the focus of work and how it is to be evaluated;
- identify the tasks of the parents and who will support them;
- coordinate the contacts the professionals have with the child and family to ensure this is proportionate and effective;
- agree how information about assessment, help, progress and further risk will be shared;
- Agree appropriate timescales for all tasks
- agree how the work of those not present at the meeting will be included in the evaluation of progress, the meeting of need, or reduction of risk;
- agree the recommendations to be made to subsequent Child Protection Plan
- Meetings.

The core group, and its individual members, have an on-going responsibility to consider whether referral to the Children's Reporter is required, where voluntary engagement with Highland Child Protection Guidelines – Interim Update July 2017 Page 43

the parents/carers/child is not able to address the assessed risks and needs.

Warning – Document uncontrolled when printed	
Policy Reference:	Date of Issue: February 2021
Prepared by: Claire MacPhee Midwifery Development Officer	Date of Review: February 2024
Lead Reviewer: Claire MacPhee Midwifery Development Officer	Version: 2
Ratified by:	Page 12 of 20

It is recommended that dates for a further two core groups should be set after the Child Protection Plan Meeting, and that these dates should be no more than one calendar month apart.

## 6.21 Unborn Child's Protection Plan

This is a multiagency plan of action managed and reviewed through a single meeting structure led by a Lead Professional from social work. They are required where evidence suggests that an unborn baby is at risk of significant harm. It will be informed by the A/N plan and should set out in detail:

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

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

## 6.22 Maternity Alert Form

This purpose of this form is to alert Hospital Staff within the maternity unit of any Child Protection Concerns and required actions when an unborn baby is placed on the Child Protection Register or when a Child Protection Order may be sought at birth. It can be accessed [here](#)

## 6.23 Decision Letter

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

## 6.24 Review Meetings

A review meeting will take place within three months of registration, with subsequent Child Protection Plan Meetings within six months if registration is continued. Changes in the child's circumstances or legal status may require any scheduled meeting to be brought forward.

Warning – Document uncontrolled when printed	
Policy Reference:	Date of Issue: February 2021
Prepared by: Claire MacPhee Midwifery Development Officer	Date of Review: February 2024
Lead Reviewer: Claire MacPhee Midwifery Development Officer	Version: 2
Ratified by:	Page 13 of 20

## 7 Additional Support Services

### 7.1 Child Protection Resources

Highland Child Protection Committee Website [www.hcpc.scot](http://www.hcpc.scot)

### 7.2 Substance Use Recovery Services

[Highland Drug and Alcohol Recovery Directory of Services](#)  
[Women, Pregnancy and Substance Use: Good practice Guidelines](#)

### 7.3 Learning Disability

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

### 7.4 FNP

Contact [FNP@Highlnad.gov.uk](mailto:FNP@Highlnad.gov.uk)

### 7.5 Smoking Cessation

[Smoke Free Highland service contacts](#)

### 7.6 Violence Against Women

[Support Services for women in Highland](#)  
[Domestic Abuse: Pregnancy and the Early Years](#)

### 7.7 Housing

[Highland Councils Housing options – Help and advice](#)

### 7.8 Financial Help

Money Talk Team can be accessed through their free helpline on **0800 085 7145** or by visiting a local Citizens Advice Bureau. This is the new name for Financial Health Check, which started in 2018 and is delivered by Citizens Advice Scotland.

The Money advice service offers free impartial money advice <https://www.moneyadvice.service.org.uk/en>  
 Highland Council welfare Support Team can be contacted on **0800 090 1004** or [welfare.support@highland.gov.uk](mailto:welfare.support@highland.gov.uk)

### 7.9 Foodbanks

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

### 7.10 Employment/Education

[Adult Education Opportunities and help](#)  
[Job Centre Plus](#) 08001690190

### 7.11 Mental Health Services

Perinatal Mood Disorder Nurse Specialist Telephone 01463 704000 ext 2234 Mobile 07786190845  
[Birth Trauma Association](#)

<b>Warning – Document uncontrolled when printed</b>	
<b>Policy Reference:</b>	<b>Date of Issue: February 2021</b>
<b>Prepared by: Claire MacPhee Midwifery Development Officer</b>	<b>Date of Review: February 2024</b>
<b>Lead Reviewer: Claire MacPhee Midwifery Development Officer</b>	<b>Version: 2</b>
<b>Ratified by:</b>	<b>Page 14 of 20</b>

[Information on specific medications during pregnancy and associated risks, Includes patient friendly portal](#)  
[Community mental health teams providing psychiatric, addiction and learning disability services](#)

## 7.12 Refugee Immigration/English as Second Language

[Highland Migrant and Refugee Advocacy \(HiMRA\)](#) Telephone: (01463) 236507 Mobile: 07388995107

[Scottish Refugee council](#)

[Highland Multicultural Friends](#)

## 7.13 Community Early Years Workers

Can work with families across the antenatal and postnatal period to support vulnerable families via Practice lead's for Early Years.

## 7.14 Resources including links Third sector support agencies

[Family Resource website](#)

[Local Information System Scotland signposting/social prescribing](#)

[Resources and ideas for parents and early years staff](#)

[Highland Information Trail](#)

## 8 Supporting Local Guidance

- [Highland Child Protection Guidance 2017 update](#)
- [Highland Practice Model GIRFEC 2017](#)
- [Women Pregnancy and substance use: good practice guidelines](#)
- [Domestic Abuse pregnancy and the early years](#)
- [Guidelines for supporting pregnant teenager and their partners](#)
- [Guidelines for practitioners working with pregnant women and new mothers with learning disabilities](#)
- [Perinatal Mental Health](#)
- [Policy for child not brought to appointments](#)
- [Policy on Management of Bruising and Injuries in Non-Mobile Children](#)
- [PROTOCOL FOR PREGNANCY AND BIRTH NOTIFICATIONS RE KNOWN SEX OFFENDERS](#)
- [The Communication and Handover of Health and Social Information Between Midwife and Health Visitor](#)
- [Responding to those at risk of forced marriage in Highland](#)
- [Responding to Female Genital Mutilation in Highland](#)
- [Infant Mental Health Guidelines pre-birth – 3 years](#)
- [Highland Information Trail](#)

## 9 Supporting National Guidance

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

<b>Warning – Document uncontrolled when printed</b>	
<b>Policy Reference:</b>	<b>Date of Issue: February 2021</b>
<b>Prepared by: Claire MacPhee Midwifery Development Officer</b>	<b>Date of Review: February 2024</b>
<b>Lead Reviewer: Claire MacPhee Midwifery Development Officer</b>	<b>Version: 2</b>
<b>Ratified by:</b>	<b>Page 15 of 20</b>

<b>A/N HPI Wellbeing Assessment</b> Aim to assess all pregnant women to allocate as Core or Additional Health Plan Indicator. Can be populated using answers to questions posed at booking back at base or used to facilitate face to face assessment for women with more complex needs. Use around 16 weeks	Mothers Name  CHI  EDD  GP Practice
-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------

Wellbeing indicator	Potential areas to explore	Record 'no issues' if required
<b>Safe:</b>	Housing  Finances  Domestic Violence/ FGM  Social Work/Child protection	
<b>Healthy:</b>	Physical Health  Mental health  Diet  Smoking  Alcohol/Drugs	
<b>Achieving:</b>	Employment  Education  Learning disability  Preparation for parenthood	
<b>Nurtured:</b>	Feelings towards Pregnancy  Experience of being parented  Experienced Adversity in Childhood, eg survivor of child	



	physical/sexual abuse/neglect, care experienced.  Support network  Any family Loss/Bereavement	
<b>Active:</b>	Physical disabilities  Enduring health problem	
<b>Respected &amp; Responsible</b>	Communication Difficulties  Criminal Justice involvement	
<b>Included:</b>	Anything getting in the way of being included in society?  Young parents, gypsy traveller, recent immigrant	

Additional Information	
Analysis and action planning.	
Name of Midwife completing assessment	Date & Time of Assessment
Health Plan Indicator <b>Core</b> or <b>Additional</b>	Is A/N plan likely to be required? <b>Yes</b> or <b>No</b>



**Multi professional single agency A/N Plan**

**My World Triangle**

**Assessment/request for service**



<b>Date of Assessment:</b>		<b>Mothers Name:</b>	
<b>EDD/Gestation:</b>		<b>DOB &amp; CHI:</b>	
<b>Address:</b>			
<b>Phone Number:</b>			

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

Name	Relationship to mother	Age	Same Address

**Professionals Involved**

Role	Name	Email	Telephone Number
Named Midwife			
Health Visitor			
Obstetrician			
GP			
Social Worker			
EYW			
CPA			

**Brief outline of reason for A/N plan**

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

