Safeguarding in Maternity UHL Obstetric Guideline

NHS University Hospitals of Leicester NHS Trust

C53/2019

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1. Introduction and Who Guideline applies to

All staff working within Maternity Services at University Hospitals of Leicester (UHL) have a role in identifying risk and ensuring children are protected from harm. Maternity staff are likely to have significant contact with families who may require support and interventions in relation to safeguarding children. All Maternity staff need to be aware of national and local procedures and their responsibility in relation to these.

Safeguarding and promoting the welfare of children is defined as:

- Protecting children from maltreatment
- Preventing impairment of children's health or development
- Ensuring that children grow up in circumstances consistent with the provision of safe and effective care; and taking action to enable all children have the best outcomes.
- Working together to safeguard children- a guide to interagency working (July 2018 – updated February 2024).

There is nothing within the Caldicott report, the Data Protection Act 1998 or the Human Rights Act 1998, which should prevent the justifiable and lawful exchange of information for the protection of children. Research and expertise show that keeping children safe from harm requires professionals and agencies to share information. Normally personal information should only be disclosed to third parties (including other agencies) with the consent of the subject of the information. Where there are concerns that a child is or maybe at risk of harm, the needs of the child must come first and consent may not be possible, the safety of the child over rules consent.

Related documents:

Female Genital Mutilation UHL Policy.pdf

Missed Antenatal Appointments UHL Obstetric Guideline.pdf

Concealed or Denied Pregnancy UHL Obstetric Guideline.pdf

2. Guideline Standards and Procedures

UHL has a statutory requirement to ensure it is compliant with Section 11 of the Children Act 2004 and with the Care Quality Commission (Registration) Regulations (2009). This means we are required to have an Executive Lead for Safeguarding. This is our Chief Nurse; who oversees the effectiveness of our Safeguarding Service provision.

We have a Maternity Safeguarding Team based at Leicester Royal Infirmary covering all UHL hospital sites including Leicester Royal Infirmary, Leicester General Hospital, Glenfield Hospital, St Mary's Birth Centre and Community Services, this also includes the Neonatal service at both LRI and LGH site.

The team consists of a Lead Matron for Safeguarding and 3 whole time Maternity Safeguarding Midwives. The team advise and support staff on any safeguarding concerns, deliver training, undertake audit, and participate in multi-agency meetings as part of the requirement of our local Safeguarding Children Boards to ensure systems and processes are in place to safeguard children. At UHL the Phoenix team also provides case holding maternity support, care and planning for vulnerable pregnant women or people and their families.

2.1 The safeguarding assessment:

When there is cause for concern whether identified through assessment or from information gained refer to:

http://www.lcitylscb.org/information-for-practitioners/

2.2 Reasons for making a referral may include:

- Where the pregnant woman or person's previous children have been removed by social care because they have suffered harm.
- Sibling to the unborn is previously known or is an open case to social care.
- Previous or current Domestic Abuse experienced in this relationship
- Concerns identified in relation to pregnant woman or person's parenting capacity including learning disability, difficulty or where there is a lack of mental capacity.

- Any child under the age of 16 who is pregnant (child sexual exploitation)
- Any child or pregnant woman/person who has been a looked after child themself.
- The lifestyle choices of the expectant parent to include association with risky adults who would be deemed a risk to the baby when born. For example the unborn baby's parents misusing alcohol and/or drugs.
- Where the pregnant woman or person discloses that they have had Female Genital Mutilation (FGM) complete the DOH risk assessment tool and refer if necessary, see (FGM policy)
- Where a pregnant woman or person DNA's for their antenatal care (Management of Missed Antenatal Appointments guideline)
- Concealed or Denied pregnancy (see Concealed/denied pregnancy guideline)
- Serious mental Health concerns, either previous or current that remain unmanaged.
- Where a pregnant woman or person is at risk of Modern Day Slavery or exploitation
- Where a pregnant woman, person or their family are at risk Human Trafficking
- Where a pregnant woman or person does not disclose who the other biological parent of the baby is, unless the pregnancy is IVF conception

This is not an exhaustive or definitive list and each safeguarding assessment should be reviewed individually, case by case.

A referral may also be made where there is information shared by the pregnant person about previous safeguarding concerns. Such as the pregnant woman or person previously being known to social care. Again there is not an exhaustive list but this must be discussed in depth with them so that there is clarity of the low risk. You must inform them of the need to share this with the Maternity Safeguarding Team, the Health Visitor and her GP. Dependant on the detail, they must be informed that the detail is not shared with social care as there is no or low risk.

The availability of support from services for the family should be shared if this is something they feel or is identified that is needed.

See appendix 2 for maternity safeguarding referral form on ICE
See appendix 7 for referral RAG rating

2.3 Midwife Booking Appointment

The booking interview gives midwives the opportunity to meet pregnant women, people and their families at the early stages of pregnancy. The purpose of the booking interview in relation to safeguarding children is to undertake an initial assessment.

In line with MECC (nhs) this opportunity should be used to consider how we use the safeguarding assessment within the booking and at all other appointments with the pregnant person. Effective communication at each appointment in relation to any safeguarding concerns should be considered carefully. Safe conversations are more productive for both parties providing constructive and holistic health promotion as an outcome.

At the booking appointment where a safeguarding concern is identified, following discussion regarding concerns with the pregnant woman or person, they should be notified of the need to share the information and the referral being made.

The Local authority (Social Care) make assessment of the identified risk, looking to support the family to reduce or remove the risk. This positive element must be highlighted and shared with the pregnant woman or person.

A multi-agency safeguarding referral form should be completed on ICE, with appropriate and adequate information. If there is an urgent safeguarding concern the Local Authority for the pregnant woman or person's demographic area (search google for 'Local Authority finder') should be called to discuss the concern enabling the start of the safeguarding plan. Otherwise, no call is needed to the local authority.

Please see appendix 8 for the Phoenix Team referral process.

It is essential that these records are maintained to a high standard so that verbal and written communication is clearly documented. Ensuring referrals are sent in a timely manner with as much information as possible (including household members and close family/friends) is included to allow a thorough and holistic assessment to be made.

2.4 The responsibility for the overall care of the pregnant woman or person is with the Midwife

In most cases this is the named community midwife as they provide the most continuity of care in the antenatal period, and as a result knows the pregnant woman or person best. However the responsibility does not lie exclusively with the named midwife but any healthcare practitioner that provides care to the mother and their family.

The Community midwife is responsible for ensuring robust communication with their team colleagues so that all team members are aware of any safeguarding referrals within their area of practice. In addition, they will ensure good communication with the Health Visiting Service and the GP for that pregnant woman or person during the ante natal and postnatal period.

- The named midwife for the pregnant woman or person will attend multi-agency meetings or ensure that a nominated colleague attends in their place. If the named midwife cannot attend they must provide a report and inform both the safeguarding team and the social worker of their non-attendance forwarding them a copy of their report. (Appendix 10 blank conference report)
- All midwives are responsible for maintaining good record keeping both written and electronic regarding all care they provide.
- Referrals to social services must include as much information as possible regarding the pregnant woman or person, their family or support network and the specific concerns in relation to safeguarding children.
- The midwife making the referral is responsible for following up the written referral once identified.
- Where problems arise in relation to inter-agency communication, the midwife will be responsible for alerting the Safeguarding Team.
- Although safeguarding concerns are often identified at booking, midwives are responsible for the on-going assessment of the pregnant woman or person throughout the pregnancy, labour and postnatal period. Concerns may be identified at any time and the individual identifying such concerns is responsible for initiating a maternity safeguarding referral on ICE (appendix 2) and/or making a referral to Social Services. Any new referral should be shared with the pregnant woman or person's named or booking midwife, whichever is relevant.
- When a woman or birthing person transfers for postnatal care, the Midwife is responsible for ensuring handover of any existing safeguarding from the transferring hospital is obtained and to commence assessment and identification of any new safeguarding concerns. A new referral would be made to the geographical local authority for the woman or birthing person. The UHL maternity safeguarding team would also need to be notified via the referral process
- Where a midwife has concerns or suspects that there are safeguarding issues, early communication with Social Services is advised to ensure all information is shared.

- All midwives are required to undertake routine enquiry regarding domestic abuse at least twice during the woman or person's pregnancy.
- When there is heightened concern that the woman or person is socially and clinically vulnerable, with concern that they could be at risk of severe harm or death in the community, an MDT must be arranged. Multi agency professionals involved with them will be invited and a care pathway will be put in place with potential to review. This meeting will be managed by the maternity Safeguarding Team.
- Where there has been a disclosure or notice of Domestic Violence via Police Protection Notice (PPN) a maternity safeguarding referral via ICE must be completed in conjunction with offering the parent a referral the to the Hospital Independent Domestic Violence Advocate (HIDVA). Consent for the referral to HIDVA is required.

3. SAFEGUARDING PROCEDURES:

3.1 Case Conference

It is the responsibility of the named midwife to attend the case conference and provide a report of the care they have given. If the midwife is unable to attend the conference themself they should arrange for a team colleague to attend or at the least provide a report (See Appendix) for the conference and inform both the safeguarding team and the named social worker of their non-attendance forwarding them a copy of the report. This report summarises the midwives involvement with the pregnant woman or person and their family during the pregnancy and/or the postnatal period. It will also include where there have been missed appointments, who the pregnant woman or person attended with, and their preparation for the baby. The midwife should document within the report their professional opinion as to whether they believe the pregnant woman or person has the capacity to safeguard the child and promote their welfare. This should include your decision as to whether the child should be placed on a child protection plan. (See appendix 3)

3.2 The Core group

The named midwife should attend the core group meeting. The Core group members review the requirements and objectives for the family set out in the Initial child protection plan. The key worker is usually the social worker and other members will include professionals with a specific involvement, including midwives. The core group should first meet within 10 working days of the case conference and the named midwife for the woman or person should ensure that either they or a member of their team attends (see appendix 4).

3.3 Pre-Birth plan

Safeguarding cases need to have a completed pre-birth plan in place by 32 weeks of pregnancy. An agreed plan from Social care should be communicated to the maternity services. It is important that Social Workers ensure that all relevant paperwork (including legal) is prepared and completed by 37 weeks gestation. (See Local Safeguarding Children's Board (LSCB) pre-birth procedures).

The Safeguarding Midwives host these meetings with social care, community midwives are not obliged to attend. It is their responsibility to make sure the plan is appropriate for maternity services and the safety of the newborn baby. The plan should include information regarding any extra support that will be required, the need for parenting logs, supervision and any restrictions on contacts/ visitors to the mother/birth parent and baby.

The safeguarding midwife will ensure that components of the plan are added to the electronic record for the mother/birth parent to ensure it is available to all staff who may provide care for the mother/birth parent and baby.

All staff are responsible for accessing the plans on the electronic record and acting appropriately. Staff involved in the care of the birthing woman or person during the birth and the early post-natal period will be responsible for accurately documenting the mother/birth parent and baby's progress in the patient notes and ensuring that any parenting logs that are required are completed (see appendix 9).

3.4 Safe discharge meeting:

A safe Discharge planning meeting (SDPM) should take place prior to discharge home if new concerns are raised or the pre-birth plan has not taken place.

The midwife should Request SDPM with social care prior to the mother/birth parent and baby's discharge from hospital to ensure there is a safety plan in place at home.

The midwife should inform safeguarding midwives of request for the SDPM and outcome of the meeting. If the SDPM is completed by the ward midwife they should complete the documentation to go in the postnatal woman or person's main notes and email a copy to the maternity safeguarding team.

Email: maternity.safeguarding@uhl-tr.nhs.uk

If the mother/birth parent and the baby are to be discharged home together, midwives working within the ward area have the responsibility to hand over any ongoing care plan and any risks identified to the community midwife who can then inform the GP and Health visitor. At each postnatal assessment, midwives should observe capacity to parent and interaction with the baby should be assessed and documented in the postnatal records and parenting logs completed if required (see appendix 9).

3.5 Interim Care order (ICO)

This is when a decision is made by the courts to grant the local authority parental responsibility. This allows the local authority to make decisions about the baby's living arrangements without the permission of the parents. This could mean that the baby goes into a foster placement alone or with its mother/birth parent into a mother and baby placement. This plan should be available prior to the baby's birth and will be on the safeguarding alert on the electronic record.

Included in the plan will be:

- Contact number of social services/ named social worker/ emergency duty team for out of hours when the birthing woman or person is admitted to hospital in established labour.
- The pre-birth plan and the request for completion of parenting logs
- Contingency plans if the baby is born outside of hospital.
- Recommendations if the mother tries to take the baby once the ICO has been granted (see appendix 6).
- When the interim care order is granted by the court the social worker will call the ward to inform the staff that the order has been granted. A time will agreed with the ward to attend to collect the baby. **The mother/birth parent of the baby will be informed of the court order by the social worker**. Prior to the handover the midwife must check the ID of the social worker and have site/ confirm the court order. The baby ID labels must be checked along with the mothers/birth parents prior to hand over of the baby
- Emotional support will be required by the mother/birth parent, and their discharge from the maternity unit facilitated.

3.6 Postnatal Care following ICO

Postnatal care should be given for both mother/birth parent and baby even if they have been separated by an Interim Care order. If together the care should be in line with NICE guidance. So, if both mother/birth parent and baby are well they can be discharged on day ten.

Handover of care should be given by the Community Midwife including safeguarding updates to the allocated Health Visitor. If mother/birth parent and baby are separated by an Interim Care Order the midwives completing the postnatal care should liaise and update each other on the wellbeing of each. Please be mindful that the mother/birth parent may want an update of their child's health.

If the postnatal care is given by a Specialist Midwife from the Phoenix team then discharge will complete around day 28, liaison with the Health Visitor should be prior to their visit and at discharge. If social care remains in place for the family there should also be liaison with them too. There may also be consideration for any joint visits if required.

4. Education and Training

All safeguarding training is part of UHL mandatory training schedule in line with LSCB Intercollegiate Guideline Document 2019.

5. Monitoring Compliance

What will be measured to monitor compliance	How will compliance be monitored	Monitoring Lead	Frequency	Reporting arrangements
Referrals and pre-birth plans should be appropriate and timely	Manual audit of electronic and paper records	Maternity safeguarding Matron	Annually	Reported to Safeguarding Assurance

6. Supporting References

- http://www.lcitylscb.org/information-for-practitioners/
- http://llrscb.proceduresonline.com/index.htm.
- HM Government, Working Together to Safeguard Children - a guide to interagency working to safeguard and promote the welfare of children (2018)
- Leicester, Leicestershire and Rutland Safeguarding Child Boards Joint Procedures, Protocols and Practice Guidance
- Thresholds for Access to Services for Children and Families in Leicester,

  https://www.leicester.gov.uk/media/178912/thresholds-for-access-to-services.pdf
- Leicestershire and Rutland, Leicester, Leicestershire and Rutland Local Safeguarding Children Boards.

7. Key Words

Safeguarding, domestic abuse, substance misuse, core group, case Conference, pre-birth plan, safe discharge, interim care order, social worker. HIDVA

The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.

As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

EDI Statement

We are fully committed to being an inclusive employer and oppose all forms of unlawful or unfair discrimination, bullying, harassment and victimisation.

It is our legal and moral duty to provide equity in employment and service delivery to all and to prevent and act upon any forms of discrimination to all people of protected characteristic: Age, Disability (physical, mental and long-term health conditions), Sex, Gender reassignment, Marriage and Civil Partnership, Sexual orientation, Pregnancy and Maternity, Race (including nationality, ethnicity and colour), Religion or Belief, and beyond.

We are also committed to the principles in respect of social deprivation and health inequalities.

Our aim is to create an environment where all staff are able to contribute, develop and progress based on their ability, competence and performance. We recognise that some staff may require specific initiatives and/or assistance to progress and develop within the organisation.

We are also committed to delivering services that ensure our patients are cared for, comfortable and as far as possible meet their individual needs.

<table>
<tr><th colspan="2">Contact and review details</th></tr>
<tr><td>Guideline Lead (Name and Title)
L Cunningham -Matron for Safeguarding within maternity</td><td>Executive Lead
Chief Nurse</td></tr>
<tr><td colspan="2">Details of Changes made during review:
Added;
• where non-disclosure of other biological parent (except in cases of IVF)
• consider when info shared about previous safeguarding concerns to reasons for making safeguarding referral.
Changed ref to A-Form to maternity safeguarding referral on ICE
Changed age or pregnant person to be referred (child exploitation) was 14 now 16.

If there is an urgent safeguarding concern the Local Authority for the woman’s demographic area (search google for ‘Local Authority finder’) should be called to discuss the concern.

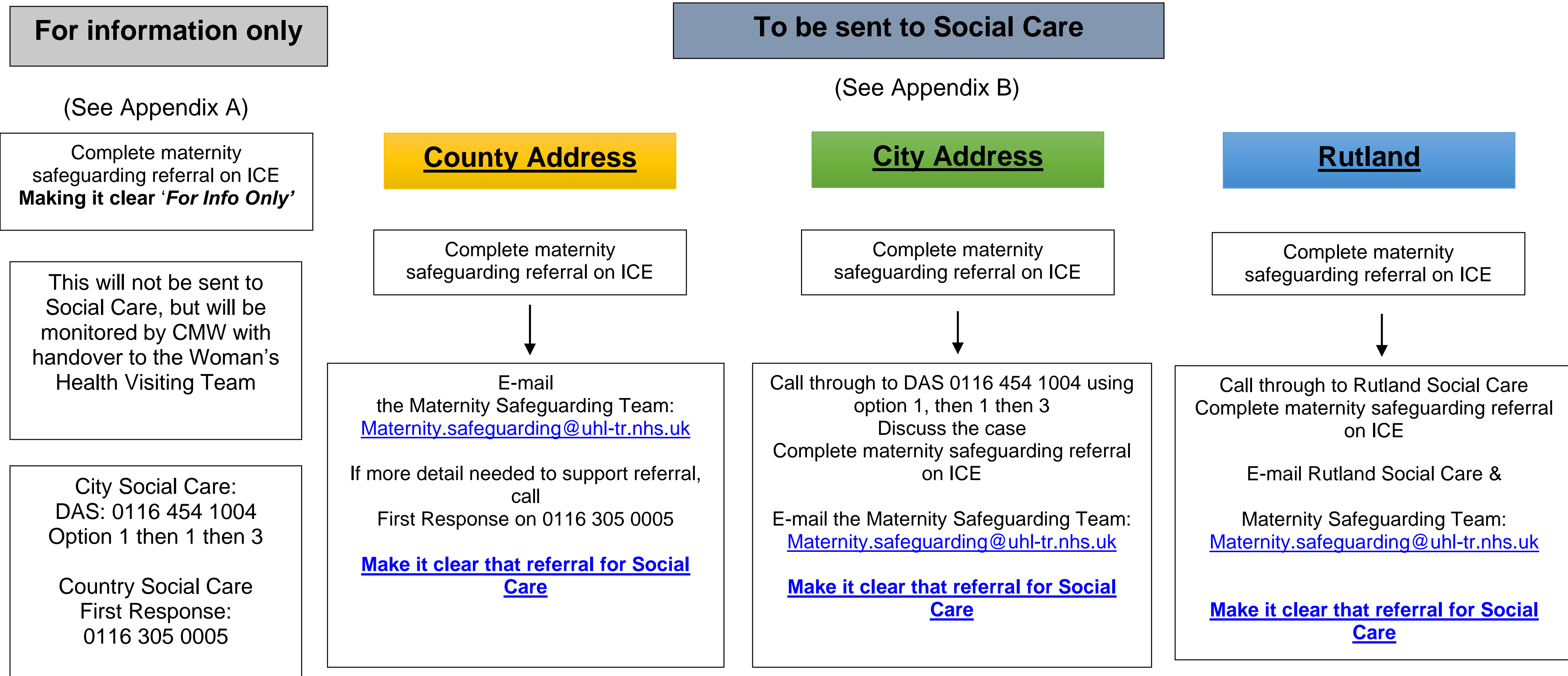
When a woman or birthing person transfers for postnatal care, the Midwife is responsible for ensuring handover of any existing safeguarding from the transferring hospital is obtained and to commence assessment and identification of any new safeguarding concerns. A new referral would be made to the geographical local authority for the woman or birthing person. The UHL maternity safeguarding team would also need to be notified via the referral process.

When there is heightened concern that the woman or person is socially and clinically vulnerable, with concern that they could be at risk of severe harm or death in the community, an MDT must be arranged.

Postnatal care following ICO added
Added example screen shot of ICE referral
Removed example of paper A Form
Added parent/carer logs

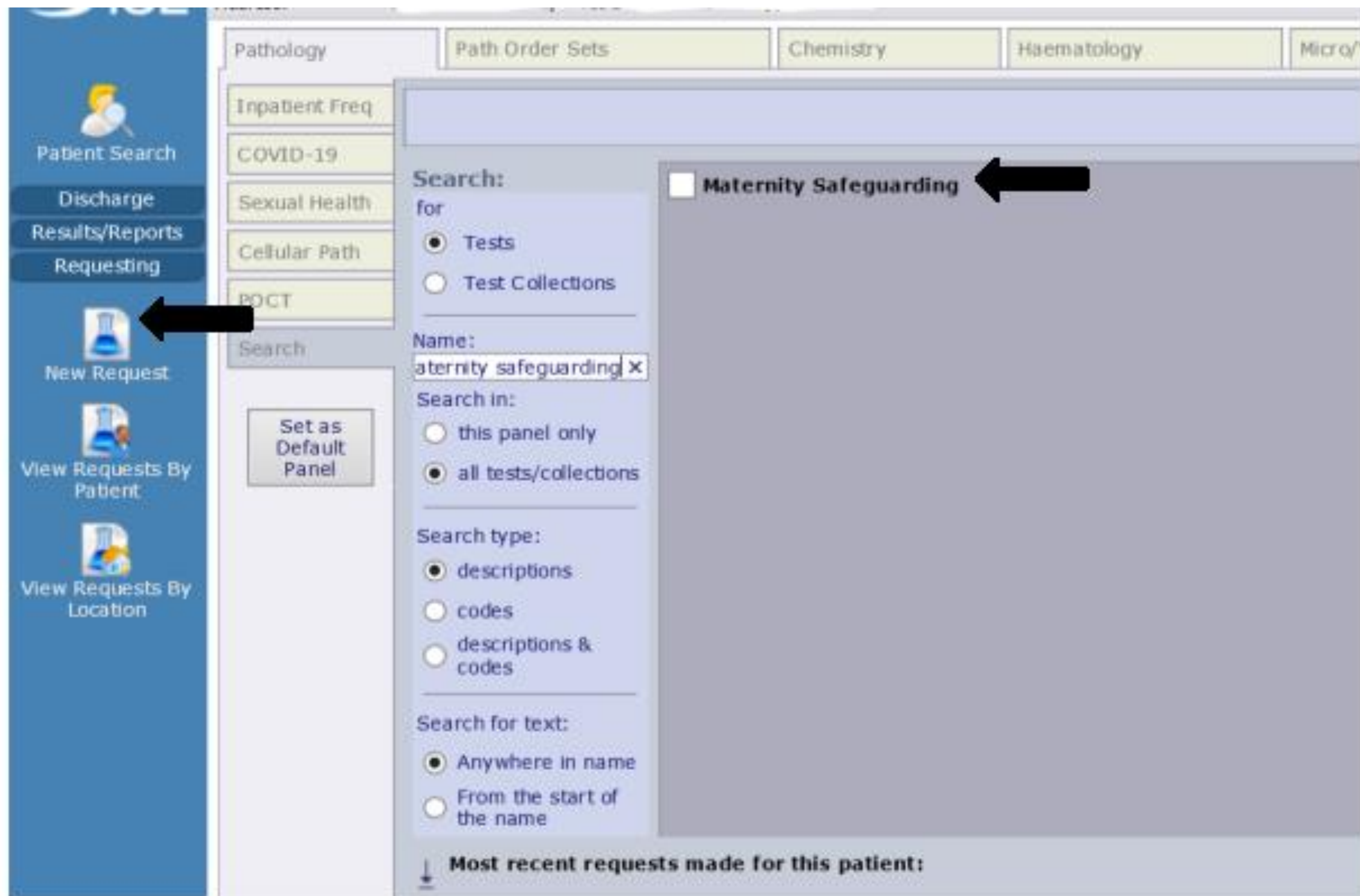
Updated references
Removed reference to fax and replaced with email contact
Minor word and terminology changes throughout</td></tr>
</table>

Appendix 1: Safeguarding referral process



If there is an immediate concern antenatally and postnatally call through to Social Care immediately for both City and Country addresses. Complete maternity safeguarding referral on ICE and e-mail the Maternity Safeguarding Team: Maternity.safeguarding@uhl-tr.nhs.uk

Appendix 2: Example screen shot of Maternity Safeguarding Referral via ICE



Appendix 3: Category definitions

Information Only

Information that identifies a previous or potential concern, but not identified as a current safeguarding concern.

Please remember:

These cases will need to be monitored with clear handover to Health Visiting Team and other relevant services.

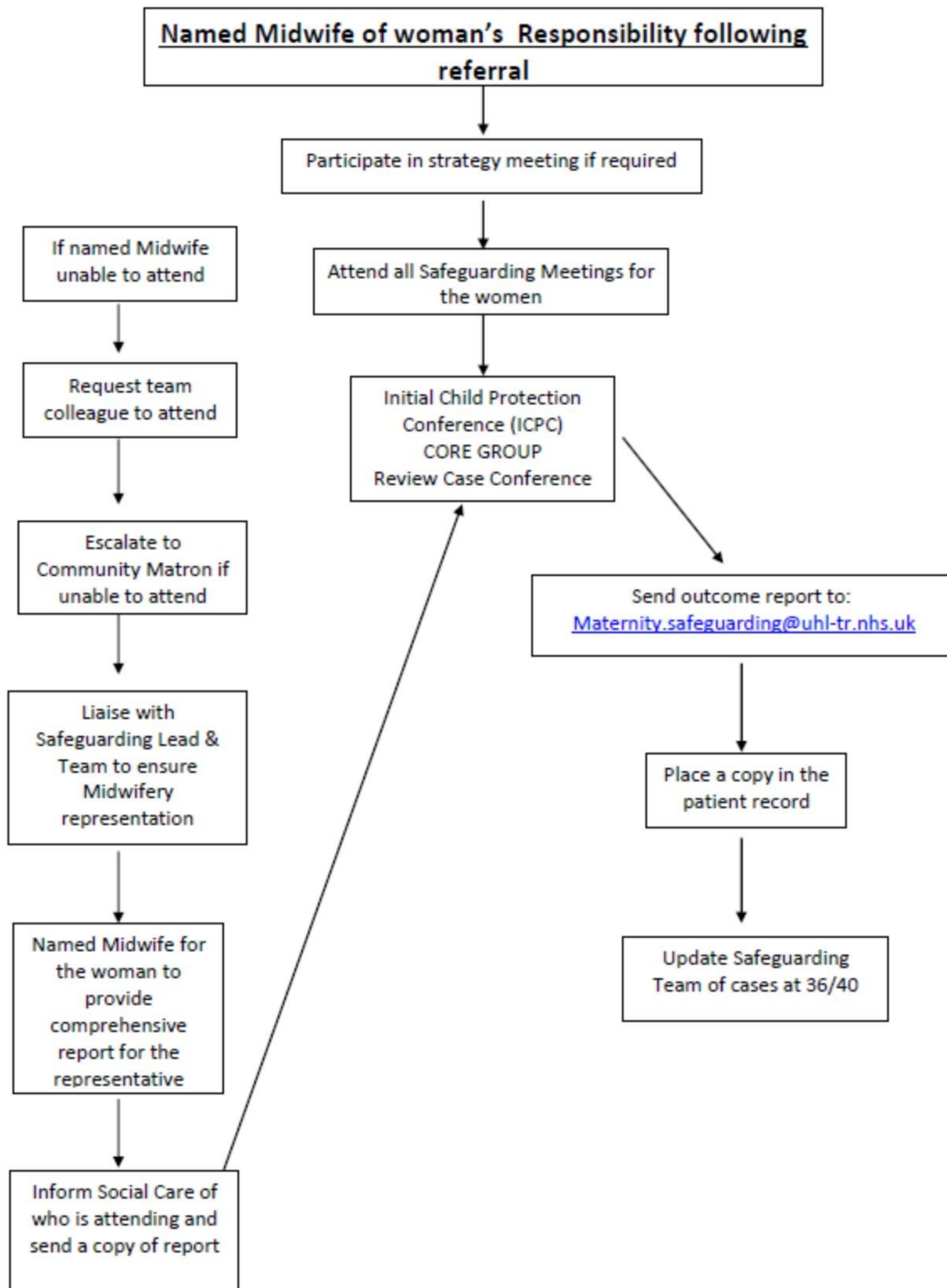
Child in Need Section 17

A child/unborn whose health and development is likely to be significant or further impaired without the provision of services.

Child Protection Section 47

Reasonable cause to suspect that a child/unborn who lives, is suffering, or is likely to suffer, significant harm.

Appendix 4: Named midwife responsibility



Appendix 5: Safe discharge planning meeting

Safe Discharge Planning Meeting (SDPM)

SDPM on Ward prior to discharge

↓

Ward Midwife to attend,
Document discussion and attendees and plan

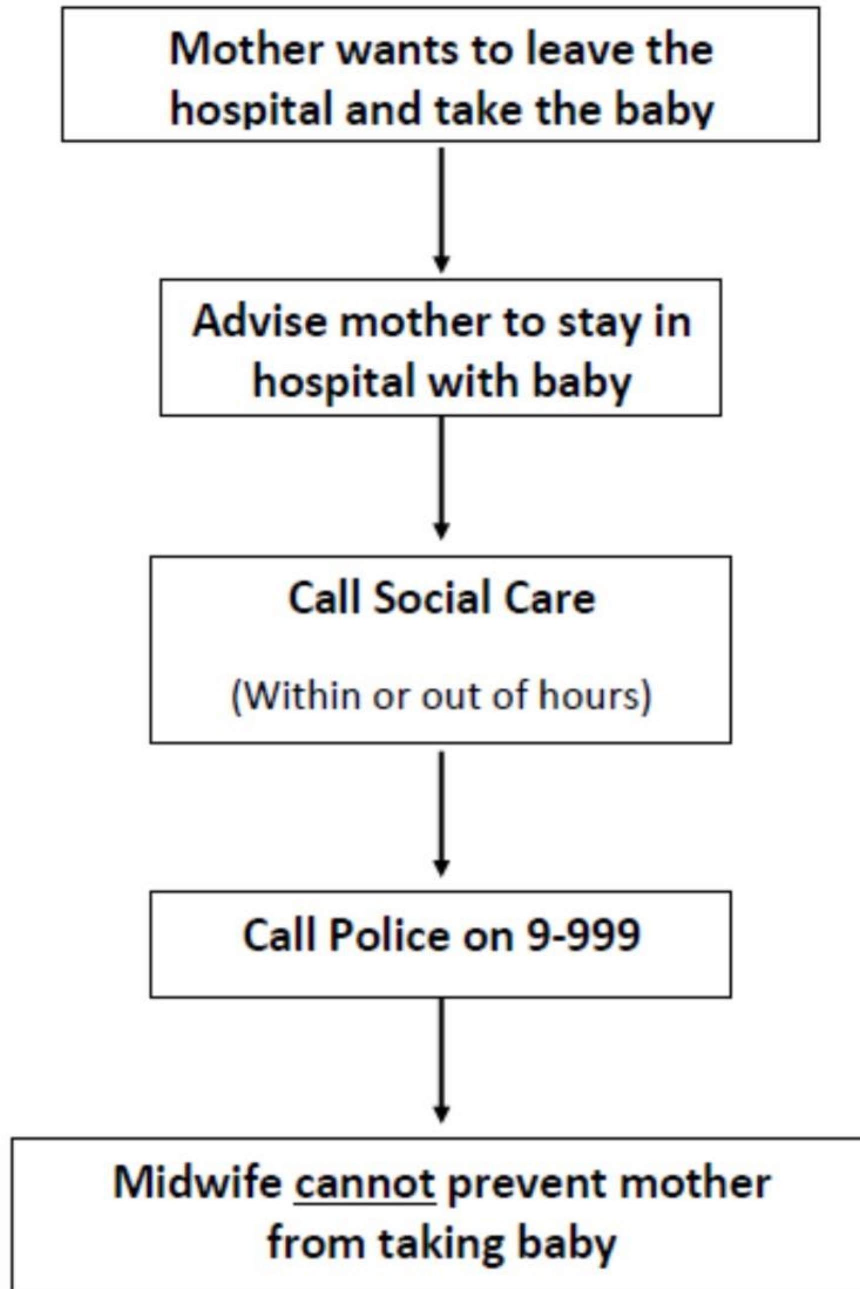
↓

Escalate to Safeguarding Midwife if necessary
0116 258 7774

↓

- **Copy of minutes to Social Care to the Social Worker**
- **Place a copy in the woman's notes**
- **E-mail Safeguarding Team**
  Maternity.safeguarding@uhl-tr.nhs.uk

Appendix 6: Interim care order



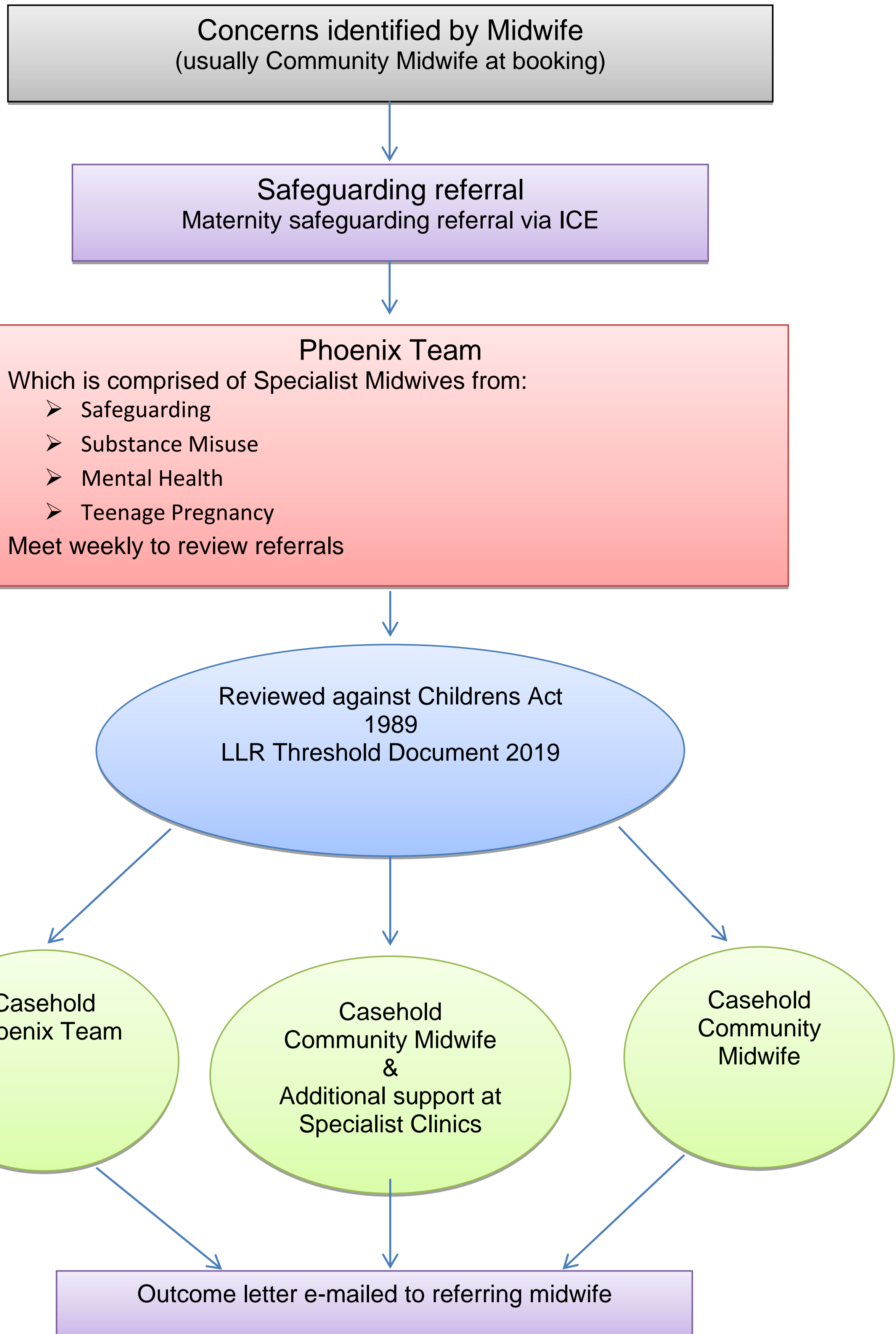
Appendix 7: RAG rating-timeliness of referrals

RAG Rating – Timeliness of Safeguarding Referrals

Rating		Action
Red Immediate risk to unborn, or siblings of unborn. Postnatally - immediate risk to baby and/or siblings. Patient term pregnancy ≥ 37/40, new safeguarding concern identified.		Immediate referral to Social Care Maternity safeguarding referral on ICE completed and sent
Amber Safeguarding concerns identified in pregnancy No immediate risk to unborn or siblings		Make a referral to Social Care Complete Maternity safeguarding referral on ICE within 1 week of identification of concern
Green Maternity safeguarding referral on ICE only		Make a referral to Social Care Complete Maternity safeguarding referral on ICE within 1 week of identification of concern

Appendix 8: Process for Case holding by Phoenix Team

(Women with extreme vulnerability)



Appendix 9: Parent/Carer logs

Stick Patient Label Here	**Safeguarding Children Parenting /Carers Logs**	DATE: ……………………… TIME: ……………………… Clinical Area:

A minimum of one log should be completed on each shift to record interactions between the child and those visiting. Please ensure they are completed in full and stored safely. These do not take place of standard recording within the medical notes for the child.

1. Who has visited the child & their relationship to the child (please ask if unsure)
2. Did you observe the interaction between parent and child?
3. Have they carried out cares for the child
4. Positive interactions noted
5. Issues of concern noted (e.g. with the child but no interaction – looking on phone etc. the whole time)
6. Length of time spent with the child – Did they spend the whole visit with the child or keep leaving the ward e.g. for a cigarette?

Key details
Mum Sarah and Dad Fred visited the ward at 10.00 and left at 10.25. Did not ask any questions or provide any care. No interaction with baby. Dad was aggressive with nursing staff on arrival on ward, security called to remove. Mum left with dad. Social worker notified of event. No calls from parents for the rest of the shift.   *OR*   *Mum (Jo) and Partner (Steve – not dad) attended at 08.30 and stayed until 12.45*   *Attended to all cares as appropriate, loving interaction noted between mum, partner and baby. Asking appropriate questions of staff. Mum frustrated at waiting for Scan result and became agitated. Spent time with mum explaining the process and reasons for the delay. Mum happy and calm.*

Continue over as required

Child’s Name:

S Number:

Date:

Person Completing: Signature: Print Name:

Appendix 10: Example of child protection case conference report

University Hospitals of Leicester NHS Trust

CHILD PROTECTION CASE CONFERENCE REPORT

You are welcome to leave blank any sections of this report that are not applicable and to attach an extra sheet with any extra information you feel is relevant
All written reports submitted to conferences are shared with parents at the conference and either quoted in or attached to the minutes.
All reports should be sent to the allocated or representing social worker before the conference.

Midwife	

Unborn Baby of:

Mother's First Name/s		**Last Name**	
DOB		**EDD**	
Home Address			
Date of Conference			

Family/Household Member Details
Include all known or suspected members of the household

First Name	Last Name	Date of Birth	Address	Relationship To Subject	Child Protection Plan		
					Yes	No	Don't know

Summary of Contact

Date	Nature of Contact	Attended		Partner Attended		Reason for DNA / Cancellation
		Yes	No	Yes	No	

Assessment

Below give your assessment of any strengths and any concerns you or your agency have identified relating to the unborn baby and his or her family.

UNBORN CHILD **Health – Development –Potential of Disability and any likely Special Needs — Mother's Emotional Attachment to Pregnancy – Family and Social Relationships Acceptance of Pregnancy.**
PARENTS: **Physical and Mental Health – Domestic Violence – Learning Difficulties – Drug and Alcohol Use – Basic Care – Emotional Warmth – Guidance and Boundaries – Ensuring Safety – Stimulation – Stability**
WIDER FAMILY AND ENVIRONMENTAL FACTORS: **Family History – Functioning – Housing – Income and Financial Constraints – Social and Community Resources – Employment – Family Social Integration**

Signed		**Print Name**		**Date**	

Notes from Conference

Following the conference please send your minutes back to the safeguarding team by email to **maternity.safeguarding@uhl-tr.nhs.uk**

Child Protection Plan	
Category (At Risk of)	**Physical Abuse / Emotional Abuse / Sexual Abuse / Neglect** *(delete as appropriate)*
Name of Chair Person:	
Midwife's understanding of Plan Outline	
Ring Safeguarding Midwife to arrange date for pre-birth professional meeting	
Date of Review Conference	

Core Group Members (to be recorded at meeting if possible)		
Designation	**Name**	**Contact Details**
Date of Core Group		

Has the report been shared with the family?	Yes / No / Don't know (delete as applicable)	If so, state the date shared	

Signed		Print Name		Date	