

## Guidelines for Maternity Services Getting it Right for Every Mother and Child

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## 1. Introduction

The contribution that maternity services make to a woman's experience of pregnancy and childbirth will have a far reaching impact on her own and her children's future health and wellbeing. Pregnancy offers a window of opportunity for service providers to make a positive difference to outcomes for a woman and her baby\* through early assessment, early support and early intervention.

Maternity services are the providers of a universal programme of health care which addresses obstetric, medical and social health and wellbeing. This programme includes screening, health improvement and health promotion, with maternity providers having a key role in ensuring that additional help and support are in place at the earliest stages in pregnancy, when required. This early intervention may offset the development or escalation of more complex needs and risks if it provides a co-ordinated, appropriate and timely response from all services working with children and families.

Using the Getting it right for every child (*GIRFEC*) approach developed through the Highland Practice Model should ensure this response happens and it is the method that all services and agencies who work with children and families, including those who work within adult services, should implement across Scotland in future (Scottish Government, 2010a).

These guidelines were developed in 2011 to offer a standardised and quality assured method of assessment and documentation across NHS Highland maternity services that support the use of the Scottish Woman Held Maternity Record (SWHMR), *GIRFEC* principles, Keeping Childbirth Natural and Dynamic (KCND) programme and Pathways for Maternity Care (NHS Quality Improvement Scotland (QIS), 2009). They acknowledge the necessity for flexibility to meet local needs and requirements.

This is the revised version. The Planning for Fairness process has been applied to these guidelines to ensure equality and diversity.

**"woman and baby"** means any woman, regardless of her age, and where reference is made to **"baby"** in conjunction with **"woman"**, it shall be taken as including reference to the woman's unborn baby during the antenatal and intranatal periods.

(Midwives rules and standards, Nursing & Midwifery Council. 2004)

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## 2. Scope of the Guidelines

These guidelines will be useful to all those delivering maternity care, particularly midwives who undertake assessment of risk and need within a health and social context.

These guidelines make reference to national and local policy and guidance that support best practice and include reference to local resources that are available to staff within NHS Highland.

## 3. Objectives of the Guidelines

These guidelines have been developed to ensure:

- Maternity services play a key role in assessment and support of health and wellbeing during pregnancy and the early postnatal period in order to reduce inequalities in health.
- The principles, values and practice models of the Highland Practice Model (*GIRFEC*) are embedded in the delivery of maternity services.
- The potential impact of parental health and wellbeing is considered in respect of the parents' and children's welfare in both the short and long term.
- Staff are signposted to appropriate resources and guidance available to support them in their role.
- Recognition that women and their families should be included in the process of assessment of health and wellbeing with their views and opinions valued and considered, and that a proportionate and appropriate response is given.

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#### 4. Tackling Health Inequalities through Public Health Practice

Inequalities in health arise because of inequalities in society and the conditions into which babies are born, how they are nurtured and how they develop will have a direct impact on their future health and wellbeing. Disadvantage is often evident before birth and accumulates throughout life therefore action to reduce health inequalities must begin at the earliest stages (Department of Health, 2010).

While a focus on vulnerable and disadvantaged families is crucial when planning services, the health gradient will only reduce if robust universal services provide the correct level of assessment, support and intervention. The strength of maternity services is that they offer all women evidence based and quality standards of care based on principles that have their foundations in guidance from across the UK, developed into locally agreed policies and protocols.

Maternity statistics demonstrate an increasing and changing population of childbearing women, which poses challenges for midwives who are often at the forefront of maternity service delivery. Public health indicators such as deprivation, lifestyle factors and complex social issues make delivering services even more challenging in order to meet the changing needs of families.

However, maternity services have the potential to contribute significantly to the health of the nation by focussing on the opportunities that adopting a public health approach can bring. Midwives in particular have a major role in delivering health messages and identifying risk factors through promoting wellbeing, self-care and behaviour change approaches. Appendix 1 details some of the public health roles that midwives undertake.

A key component to providing the correct level of support is the ability to identify risk and need and ensure appropriate, individualised care is provided within a scale and intensity that is proportionate to the level of risk, need or disadvantage. Partnership working with multi-disciplinary and multi-agency teams and services provides an opportunity to deliver truly client-focussed individualised care. Awareness of the circumstances and communities in which women and families live and the ability to recognise factors which may make them especially vulnerable are crucial to delivering effective care.

Developing an understanding of the different roles and responsibilities within a multi-agency arena through joint training and working should ensure that practitioners are confident to engage with other services and agencies. Ensuring every child has the best start in life puts midwives at the centre of public health policy.

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## 5. Getting it right for every child - *GIRFEC*

*GIRFEC* is a programme of change across Scotland which provides practitioners with principles and practice models that enable them to focus on improving outcomes for all children. *GIRFEC* supports and builds on good practice delivered by universal services, with a shift in focus from intervening when a crisis occurs towards prevention, early support and early intervention (Scottish Government, 2006).

The principles of *GIRFEC* describe provision of co-ordinated help for children and families to ensure that their health, wellbeing and development are not compromised by any delay in response, but provided in a timely manner, proportionate to their needs. Providing the correct level of support before problems escalate requires that all agencies work together to ensure Scotland's children get the best start in life.

Services to babies and their families are delivered through universal health services and most families will only require a core programme of care, delivered by the maternity team and later from public health nurses/ health visitors (PHN/HVs) and GPs. Some babies and families may require additional help from within health services, for example the community paediatric team. Others will require co-ordinated support from another agency or service such as social work, who will work closely with the health team. The *GIRFEC* approach delivered in Highland is known as the Highland Practice Model and the service delivery model can be found in Appendix 2.

In order to achieve their potential and best outcomes, every child needs to be safe, healthy, achieving, nurtured, active, respected and responsible and included (SHANARI). These **Wellbeing Indicators** form part of the *GIRFEC* Practice Model and have been identified from extensive research into child development as areas which can make a positive difference to a child's life. They should be used as an aid for practitioners to identify when additional support may be required.

If potential concerns are identified after considering the Wellbeing Indicators, the **My World Triangle** assessment tool provides an ecological model to enable practitioners to reflect on the whole world in which the child lives. It can assist practitioners to consider if any of the three domains that make up the assessment: 'How I grow and develop', 'What I need from people who look after me' and 'My Wider World' are likely to impact on wellbeing and development (Appendix 3). This should enable practitioners to focus on the actions required to ensure best outcomes for all children.

The use of the Wellbeing Indicators and the My World Triangle, offers practitioners across all agencies and services the same assessment framework to facilitate a faster response to need by the use of a common language and process. *GIRFEC* places the importance of understanding risk within a framework that makes communication between practitioners more easily understood and therefore concerns can be acted on more quickly. The Practice Model acts as a communication tool, is outcomes focused and promotes partnership working.

Highland Children's Services Practice Guidance - Getting it right for every child addresses the models, principles and practice in greater detail. It should be familiar to all staff and further copies are available at [http://www.forhighlandschildren.org/5-practiceguidance/index\\_10\\_1211294694.doc](http://www.forhighlandschildren.org/5-practiceguidance/index_10_1211294694.doc)

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## 6. *GIRFEC* and Maternity Services

The premise of *GIRFEC* is focussed on the needs of a child; however within a maternity context the approach can be used as a model which provides the same principles and tools that can reflect the needs and risks to a woman and her baby. Therefore, early assessment during pregnancy can identify when a woman may require additional support to enable her and her baby to achieve the best health and wellbeing outcomes. Moreover, assessment and provision of support networks that promote health and wellbeing is core to the role of the midwife which is an important outcome of maternity care.

Identifying the need for early intervention is important when planning care and can often prevent escalation or deterioration of a current situation. Therefore identifying risk and need in pregnancy is extremely important. Early intervention is described as:

- Early in the life of a child or unborn child
- Early in the spectrum of complexity
- Early in the life of a crisis

*GIRFEC* requires that each child should have a plan which considers their health and wellbeing. Within universal health services this plan is developed by the named person who is responsible for delivering a service to the child. In pregnancy that person is the woman's named community midwife caseload holder who plans care for the woman and her baby with the wider maternity team as required, and records the details of this in the SWHMR.

The KCND Pathways for Maternity Care (NHS QIS) and the Refreshed Framework for Maternity Care (SG 2011) principles also promote the role of a named midwife for each woman. This is the case in most areas across Highland although some of the smaller midwifery teams may have the midwifery team leader as the named midwife. The named midwife will be responsible for undertaking risk assessment and managing the caseload by ensuring each woman follows the correct pathway of care, working closely with the obstetrician and the woman's GP

When considering if additional support may be required around social need, the named midwife should consider the adaptation of the 5 key *GIRFEC* questions to help decision making. These are:

- What is getting in the way of this woman or baby's wellbeing?
- Do I have all the information I need to help this woman or baby?
- What can I do now to help this woman or baby?
- What can my service do to help?
- What help, if any, may be needed from others?

If any concerns are raised by any other agency or service that has contact with the mother, which may have the potential to affect the wellbeing of her and her baby, these should be shared with the named midwife. The midwife may need to discuss these concerns with the local Child Protection Advisor (CPA) and share these concerns as appropriate (see *Interagency Guidelines to Protect Children and Young People in Highland* for Child Concern Form, Highland Child Protection Committee, 2011). The guidance can be found at:

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[http://forhighlandchildren.org/2-childprotection/publications\\_44\\_1060070483.pdf](http://forhighlandchildren.org/2-childprotection/publications_44_1060070483.pdf)

The assessment of risk and need may identify that it is necessary to deliver additional or intensive support to a woman and baby through other disciplines within health or through a co-ordinated multi-agency approach, with one multi-agency plan. The need for additional resources from out with health services should be discussed and the assessment shared with the Integrated Service Officer (ISO) who is the first point of contact in social work for health staff, when early intervention is deemed appropriate. ISOs are experienced social workers who support the early intervention process and can offer advice, guidance and support to practitioners on how additional needs may be met.

In other complex situations the midwife will need to direct her concerns to the social work team manager.

An Antenatal Plan: additional support for mother and unborn baby (revised August 2012) should be completed and will assist the named midwife to undertake assessment of risks and needs for the mother and her baby (See section 7.3 for more details on the Antenatal Plan).

If a multi-agency plan is required the midwife will contribute to this plan, which is co-ordinated by an identified Lead Professional, which may or may not be the midwife. The named midwife will continue to provide her/his core role and function to support health and wellbeing in pregnancy based on assessment of risk and need.

If assessment identifies that there are risks of significant harm then formal Child Protection Procedures must be followed (Highland Child Protection Committee, 2011)

## 7. Maternity Care

The aim of maternity care is to ensure whenever possible the best outcomes for mothers and babies. The most effective way to achieve this is through a process of continuous risk assessment to ensure evidence based high standards and quality care to all.

There are many policies, standards and guidelines that are available to support staff and enable assessment of obstetric and medical risk in pregnancy. However, the Confidential Enquiry into Maternal and Child Health (CEMACH) now called CMACE (Centre for Maternal and Child Enquiries) provides evidence that demonstrates that adverse pregnancy outcomes are often linked to vulnerability and social exclusion (Lewis, 2007). Therefore, the wider public health and social determinants of health must be recognised as extremely important when planning care.

Women who are vulnerable or with socially complex lives are far less likely to seek antenatal care early. They are less likely to stay in contact with maternity services unless they are designed to meet their specific need, which often requires flexibility to deliver services in a different way. Ensuring that appropriate support is provided may be achieved through developing opportunities that support multi-disciplinary and multi-agency working.

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Many women may be in touch with other health providers including their GP, PHNs/HVs, addictions services and mental health services and it is important that these health providers ensure close working with the woman's named midwife. There may also be contact with other agencies and services both before and during pregnancy which may include local authority and voluntary organisations. It is therefore important that maternity care providers use the contacts they have with other services innovatively to facilitate joint working, using opportunistic contacts to undertake maternity care and deliver health messages that support best practice and improve outcomes.

## 7.1. Pre-pregnancy Care

Although maternity services do not always have an opportunity to be involved in pre-pregnancy care for women in their first pregnancy, they can influence future pregnancy planning through providing contraceptive and family planning advice. This is particularly important for women with complex social needs who may view their own health and wellbeing, including their sexual health, as low on their priorities.

The importance of brief intervention and behaviour change approaches that tackle lifestyle issues should be addressed pre-conceptually. These include:

- Smoking
- Alcohol
- Drug use
- Nutrition and exercise: including folic acid, vitamin supplementation, obesity
- Dental health
- Sexual health and contraception
- Health screening and surveillance

Opportunities to raise these issues should occur preferably before pregnancies are planned and should form part of general health and wellbeing discussions that begin with school age children around sexual health and relationships, and continue into all contacts with health professionals in primary care. Midwives may work in collaboration with education and voluntary sector colleagues to contribute to these agendas in schools, early year's settings and with youth workers.

Mental health and wellbeing is an important area to address pre-pregnancy, particularly when there is a personal or family history of serious psychiatric disorders. A woman contemplating pregnancy should have an opportunity to discuss her history with her GP and referral to the mental health team should be considered as required. The **Perinatal Mental Health: Good Practice Guidelines** (NHS Highland, 2008) should assist staff when working with women with mental health issues. They are presently being reviewed.

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## 7.2. Antenatal Care

Pregnancy is often the first time in a woman's life that she enters into a system of regular contact with health staff and it offers an ideal opportunity to involve women and their families in their personal health and wellbeing, engage them in health improvement and promotion, and support behaviour changes that can improve their future health.

The Pathways for Maternity Care have now been implemented across Scotland to support the principles within the original *Framework for Maternity Services* (Scottish Executive, 2001). These Pathways have been developed as a guide to enable practitioners to undertake risk assessment through pregnancy, birth and postnatally, that recognise that risk is dynamic and can change (NHS QIS, 2009). The pathways offer general guidance for maternity staff around assessment of obstetric, medical and social risk to mother and baby, and support the use of the SWHMR. The Refreshed Framework for Maternity Care in Scotland (SG 2011) now embraces a broader public health focus to addressing health inequalities through the use of a strengths / assets based approach. The Refreshed Framework compliments the original and should be used alongside it.

The SWHMR has also been reviewed and version 6 is now in use across NHS Highland. The social needs questions ask about issues such as smoking, drug and alcohol use, mental health, housing, domestic abuse and disabilities and are more detailed than previously. It is expected that local guidance and additions should assist staff in providing the correct support and decision making at local level (Healthcare Improvement Scotland 2011).

There have been a suite of best practice guidelines and protocols developed within NHS Highland that focus on pregnancy and the early years in an attempt to improve the quality of care and support best practice and decision making. These are available on the NHS intranet and For Highlands Children site. A short synopsis of these and other national policies that may influence pregnancy and early year's provision is included in Appendix 4.

Although the Pathways for Maternity Care do not offer advice on home visiting to undertake care in pregnancy, good practice would support the need for at least one home visit for women identified as having additional needs. Home visiting must occur more routinely for women with intensive or complex issues to ensure a robust assessment of their support needs and allow more time for discussion and planning appropriate care.

Providing information to women about screening, surveillance and health promotion in pregnancy is essential and is detailed in **Highland's Information Trail** which should be used as an aide to ensure a standardised, quality assured approach across Highland (HC & NHS Highland, 2012). [http://www.forhighlandschildren.org/4-icspublication/index\\_53\\_3031212082.pdf](http://www.forhighlandschildren.org/4-icspublication/index_53_3031212082.pdf) or <http://intranet.nhsh.scot.nhs.uk/Org/CorpServ/PublicHealth/Pages/Default.aspx>

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### 7.3 Risk Assessment

The importance of high quality antenatal care is described in the policy document 'Equally Well' as a need to address risks early and improve outcomes for vulnerable families (Scottish Government, 2008a). Assessment of risk and need is fundamental when planning care and maternity services are well placed to identify those families that may require additional or intensive support to enable them to meet their optimal health and wellbeing needs.

The role of the midwife is fundamental to this and as it is protected in statute, only those with effective, live registration can provide midwifery care as described by the Nursing & Midwifery Council (Nursing & Midwifery Council, 2004). Midwives are experienced practitioners in normal childbirth (antenatal, intrapartum and postnatal care) and are skilled in recognising deviations from normal and ensuring that women are provided with the most appropriate pathway of care for their maternity journey. Midwives must be clear about their roles and responsibilities when working in a multi-agency context where they may be informing and contributing to multi-agency plans.

The process of assessment begins at booking and midwives will follow the '**Revised procedure for the communication and handover of health and social information between midwife and health visitor**' to ensure that joint working and sharing information as required with the wider maternity team begins at the earliest stages in pregnancy (HC & NHS Highland, 2012 Appendix 5).

[http://www.forhighlandschildren.org/4-icspublication/index\\_50\\_1095321166.pdf](http://www.forhighlandschildren.org/4-icspublication/index_50_1095321166.pdf)

or NHS Highland Intranet

[http://intranet.nhsh.scot.nhs.uk/PoliciesLibrary/Documents/Communication%20and%20Handover%20of%20Health%20and%20Social%20Information%20between%20Midwife%20and%20Public%20Health%20Nurse%20\\_%20HV.pdf](http://intranet.nhsh.scot.nhs.uk/PoliciesLibrary/Documents/Communication%20and%20Handover%20of%20Health%20and%20Social%20Information%20between%20Midwife%20and%20Public%20Health%20Nurse%20_%20HV.pdf)

In order to manage caseloads and ensure the correct pathway of care is followed, various tools are available to support staff including the use of the Wellbeing Indicators and NHS QIS Pathways for Maternity Care as previously described.

The development of **Health Plan Indicators for maternity care in NHS Highland** has assisted practitioners to identify women and babies who may be more vulnerable within a social context (Appendix 6). The indicators have helped to assess which mothers may require additional, which includes intensive support from within a multi-disciplinary or multi-agency perspective and therefore indicated when to complete an Antenatal Plan. A Pathway of Care for Vulnerable Families (0-3) has since been published by the Scottish Government (2011) and a diary insert has been developed to be included in the Pathways for Maternity Care. This gives examples for identifying some of the most vulnerable women and families (Appendix 7). These tools can be used with the 5 *GIRFEC* questions to consider additional needs (page 7).

If additional social needs are identified during pregnancy the completion of the **Antenatal Plan** (Appendix 8) as a supplement to the SWHMR should be undertaken. The Antenatal Plan is the pregnancy equivalent of the Childs Plan and allows a *GIRFEC* focused risk assessment of mother and baby's needs and risks and has recently been revised (August 2012).

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The revised SWHMR (version 6) combined pregnancy and postnatal record contains details about *GIRFEC* models and language. The *GIRFEC* practice model (wellbeing indicators and my world triangle) is very much a communication tool to be used with women and families to ensure they are included in planning their own care.

The SWHMR contains details of health information which must not be shared across agencies therefore the use of the Antenatal Plan for assessment will demonstrate assessment, analysis and decision making which is appropriate and proportionate to share when requesting a service to provide additional support.

Requests for resources from another agency or service can be made through the Antenatal Plan, which replaces the need for the different request forms used across agencies. The Antenatal Plan does not contain any confidential health information and therefore makes sharing the health professional's assessment of additional or intensive social need with another agency more straightforward. **Guidance for completing the antenatal plan** should be followed and partners to the plan and who it has been shared with documented (Appendix 9). The Antenatal Plan should be shared with the woman's GP, PHN/HV and obstetrician. The Antenatal Plan can be used to populate a **multi-agency Child's Plan** if needed following birth.

Where there are significant events that occur for the mother during pregnancy such as a breakdown in relationships, attendance at A&E or other concerns for the mother, the **Mother's chronology of significant events** should be completed and the details shared with the PHN/HV (Appendix 10). If a Lead Professional role is required or a change in this role is made, this should also be detailed in the chronology.

Missed appointments are important to include in a chronology and if a woman does not attend an appointment, good practice would suggest that this should always be followed up by her named midwife. A woman may have just forgotten, but missed appointments may indicate that her plan of care may need to be reviewed or adapted and she may have additional needs. The chronology if used should be kept in the mother's summary record by the midwife and details shared as appropriate. A copy should be sent to the PHN/HV at handover, together with the completed handover records.

If an antenatal mother is missing from known address, the midwife should discuss with the CPA. The CPA will assist with a decision to complete the missing from known address checklist and whether a Missing Family Alert is required to inform staff in other areas. This is in line with the newly developed Missing Family Alert Protocol.

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## 7.4 Child Protection

Any concerns around risk and need identified at any stage during pregnancy, must be communicated with the local CPA and if required a child concern form should be completed and shared with social work as detailed in the **Interagency Guidelines to Protect Children and Young People in Highland** (Highland Child Protection Committee, 2011).

It is important that effective communication with the wider maternity team (GP, obstetrician, PHN/HV) and social work is maintained at all stages in pregnancy, and a prebirth planning meeting must take place at around 28 weeks where there are any issues of concern, to ensure all partners supporting a co-ordinated plan for the baby are involved and included. When a case of potential significant harm to a baby is identified at any stage in pregnancy, immediate Child Protection Procedures must be followed.

A Child Protection Plan meeting should take place no later than 28 weeks of pregnancy or as soon as possible from the concern being raised, and certainly within 21 days of the concern (Scottish Government, 2010b). All partners to the plan should be included in the meeting and agreement can be made at any stage of pregnancy or following birth for the baby to go on the Child Protection Register, if deemed necessary. All decisions and actions must be clearly documented in the woman's medical notes held in the maternity base where she will deliver. If a woman is transferred to another unit for delivery this information must be communicated to the delivering unit as a matter of urgency.

At the time of delivery the midwife in charge should contact the appropriate social work team or the emergency social work team out with office hours to inform them of the birth. The named community midwife must also be informed of delivery as soon as is practically possible. Health staff should remember that having a child's name on the Child Protection Register does not offer it any protection unless they continue surveillance and act appropriately by following child protection procedures and liaise closely with the CPA and social work. Health staff must ensure that they are clear about their roles and responsibilities and always act within their professional codes of conduct which support their practice (Nursing & Midwifery Council, 2008).

When a decision has been made to remove a child to a place of safety at birth as detailed in a Child Protection Order, this must be clearly documented in the medical notes and the woman will require to be delivered at a unit that will facilitate this (Raigmore for North Highland). The midwife in charge of the delivery must inform social work immediately and also inform the named community midwife, who will continue to provide support to the mother.

Training around child protection, *GIRFEC* and domestic abuse are available for all staff in NHS Highland and The Highland Council and attendance is a requirement to support best practice. Details can be found on the relevant intranet sites.

For those women whose babies will not go home with them due to Child Protection Orders or chosen adoption, professionals should continue to offer the same high standard of care to women and treat them with dignity and respect.

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## 7.5 Continuing Support, Postnatal Care

Close liaison and effective handover with the family's PHN/HV and GP must be maintained throughout pregnancy and the postnatal period to ensure appropriate provision of care is maintained and sources of further help and support are sought following birth.

Opportunities to deliver early support and intervention to a woman in pregnancy should mean that by the time her baby is born, she should have experienced a high quality joined up service to support, enable and empower her transition into motherhood. The importance of investment in the early years particularly for the most vulnerable through working creatively with partners in other agencies is discussed in Better Health, Better Care (Scottish Government, 2007).

Furthermore, the impact that pregnancy and the early years can have on outcomes for women and their families is documented in 'The Early Years Framework' which recommends that:

*"Parents have access to world class antenatal, maternity and postnatal care that meets their individual needs"* (Scottish Government 2008b: 11).

Postnatal care in NHS Highland is provided in line with recommendations of Pathways for Maternity Care which supports continuous assessment of risks and needs for mother and baby (NHS QIS 2009). Advice around lifestyle factors and general health and wellbeing should continue following birth and particular importance should be placed on support and advice around attachment and parenting.

The implications of poor quality attachment relationships with adult carers on infant mental health are becoming more widely understood. Recently developed **Infant Mental Health (prebirth – 3 years): Best Practice Guidelines (Highland 2012)** are available to support staff to facilitate positive attachments. It can be accessed at [http://www.forhighlandschildren.org/4-icspublication/index\\_56\\_3923857013.pdf](http://www.forhighlandschildren.org/4-icspublication/index_56_3923857013.pdf)

or NHS Highland intranet

[http://intranet.nhsh.scot.nhs.uk/PoliciesLibrary/Documents/Infant%20Mental%20Health%20\(prebirth%20%203%20years\)%20Best%20Practice%20Guidelines%20North%20Highland.pdf](http://intranet.nhsh.scot.nhs.uk/PoliciesLibrary/Documents/Infant%20Mental%20Health%20(prebirth%20%203%20years)%20Best%20Practice%20Guidelines%20North%20Highland.pdf)

The universal provision of care is handed over to the PHN/HV at around 10 days following birth and he/she should be fully informed of any additional / intensive needs the child and family may have by the named midwife. Hopefully the PHN/HV will have met the mother before her baby is delivered. Antenatal contact by the PHN/HV is particularly important for those women who have additional/intensive needs identified in pregnancy by the named midwife.

PHN/HVs deliver a universal service to children and families in line with local and national policy that supports the recommendations of Health for all Children (Hall 4 – Hall & Elliman, 2003) and the Hall 4 guidance produced by the Scottish Executive (2005). Hall 4 recommended the use of Health Plan Indicators (HPIs) to determine contact and support required for the child based on assessment of need. This is captured within the Child Health Surveillance Programme (CHSP), ISD Scotland.

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As experts in child health and development, PHN/HVs are well placed to work with partners across agencies and services to ensure children and families receive the correct level of support to enable children to reach their full potential. They can identify when children are in need of further help or protection and share their concerns and assessments with social care colleagues. For more details of their role see NHS Highland Public Health Nursing – Early Years, Best Practice Guidance (North NHS Highland version) 2011.

[http://intranet.nhsh.scot.nhs.uk/PoliciesLibrary/Documents/Communication%20and%20Handover%20of%20Health%20and%20Social%20Information%20between%20Midwife%20and%20Public%20Health%20Nurse%20\\_%20HV.pdf](http://intranet.nhsh.scot.nhs.uk/PoliciesLibrary/Documents/Communication%20and%20Handover%20of%20Health%20and%20Social%20Information%20between%20Midwife%20and%20Public%20Health%20Nurse%20_%20HV.pdf)

Highland council staff can access it from the For Highlands Children website  
<http://www.forhighlandschildren.org/4-icspublication/>

## 7.6 Supporting Parents

In order to support the important role that parenting has on future outcomes for children, many staff across agencies in Highland have been trained to deliver different types of parenting support. The investment in parenting support can ensure staff are able to inform parents of the benefits of practical things they can do to promote the bond with their infant, such as baby massage and affectionate communication.

The focus on redesign of parenting preparation has been under discussion for some time and local and national work is being developed. In conjunction with partners Highland is developing a parent education and support framework. The needs of adult learners will be considered and recommended standards provided to ensure parents have access to high quality parenting support and advice. Furthermore, a national Parenting Strategy will shortly be published by the Scottish Government.

The Scottish Antenatal parent education pack has been developed by NHS Health Scotland and contains a variety of activities and discussion topics. Staff are required to undertake training around its use and understand the use of motivational interviewing and behaviour change models that facilitate self-motivation to make positive health and wellbeing choices.

## 8. Conclusion

The early experiences that a child has will shape its future health and wellbeing as described in the 'Integrated Children's Plan: For Highland's Children 3 (Joint Committee on Children & Young People, 2010). Maternity services that focus on a social model of care firmly embedded in the wider community where women and their families live will help to achieve better outcomes for children and families. This will require a new way of working that includes building partnerships that cross conventional care boundaries but yet respect and understand each other's unique roles and area of expertise.

Multiagency assessment, planning and delivering care requires a clear vision for services with effective leadership that supports frontline staff. This will enable the

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interface of maternity services with other agencies or services which is important if health inequalities are to be tackled.

Families will judge the experiences of maternity health care provision as a platform for future engagement with services. Hopefully theirs will be a positive experience and even when health or social problems may become evident through this journey, families should feel that they have been engaged in decisions and processes, and informed and involved in their care. Therefore maternity services play an important role in ensuring that those early contacts and assessments which they undertake support the provision of services within the Highland Practice Model (*GIRFEC*) approach.

Maternity practitioners work within an environment that understands the importance of assessment of risk and need and *GIRFEC* provides health staff with the same practice models and tools as our partners in the local authority and third sector (voluntary and private) when assessing and planning care within a health and social context. This approach will help to ensure that effective early intervention and support is provided in an attempt to offset the often inter-generational factors that continue to undermine the health and wellbeing of children and families every day.

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## Appendix 1

### Midwife's role in Public Health

#### Includes:

- Discussion
- Counselling
- Awareness raising
- Information giving
- Screening and surveillance
- Delivering brief intervention and managing behaviour change theories

#### Related topics include:

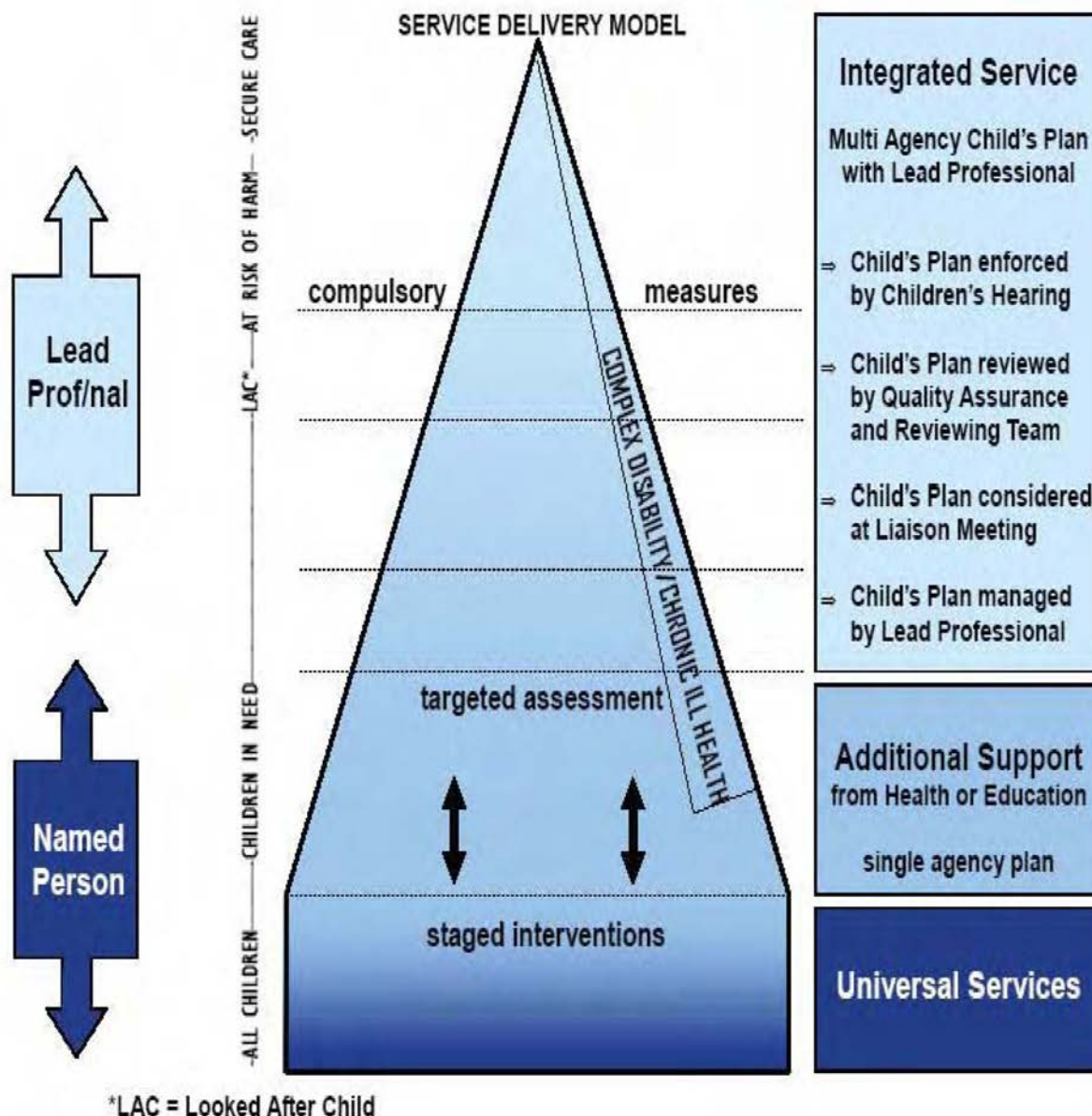
- Nutritional health and wellbeing  
Vitamin supplementation – increased awareness of importance of folic acid before conception and in early pregnancy, Vitamin D, diet, exercise, overweight and obesity – risk factors and weight management
- Oral health
- Alcohol
- Drugs – illicit and prescribed
- Smoking
- Blood born viruses - HIV, syphilis, Hepatitis B, Hepatitis C
- Pregnancy and newborn screening and surveillance
- Breast feeding support and implementation of UNICEF/BFI
- Pelvic floor exercises
- Contraception, sexual health and cervical screening advice
- Rubella screening
- Facilitation of one-to-one care in labour, supporting and enabling women to make informed choices
- Additional and co-ordinated support for vulnerable women including teenagers, women who may be subject to domestic abuse, substance misuse issues, perinatal mental health support, homeless women, non-attenders, learning disabilities, non English speaking women
- Parenting support – including facilitation and co-ordination of parenting programmes, attachment and promotion of infant mental health
- Support for parents of premature infants

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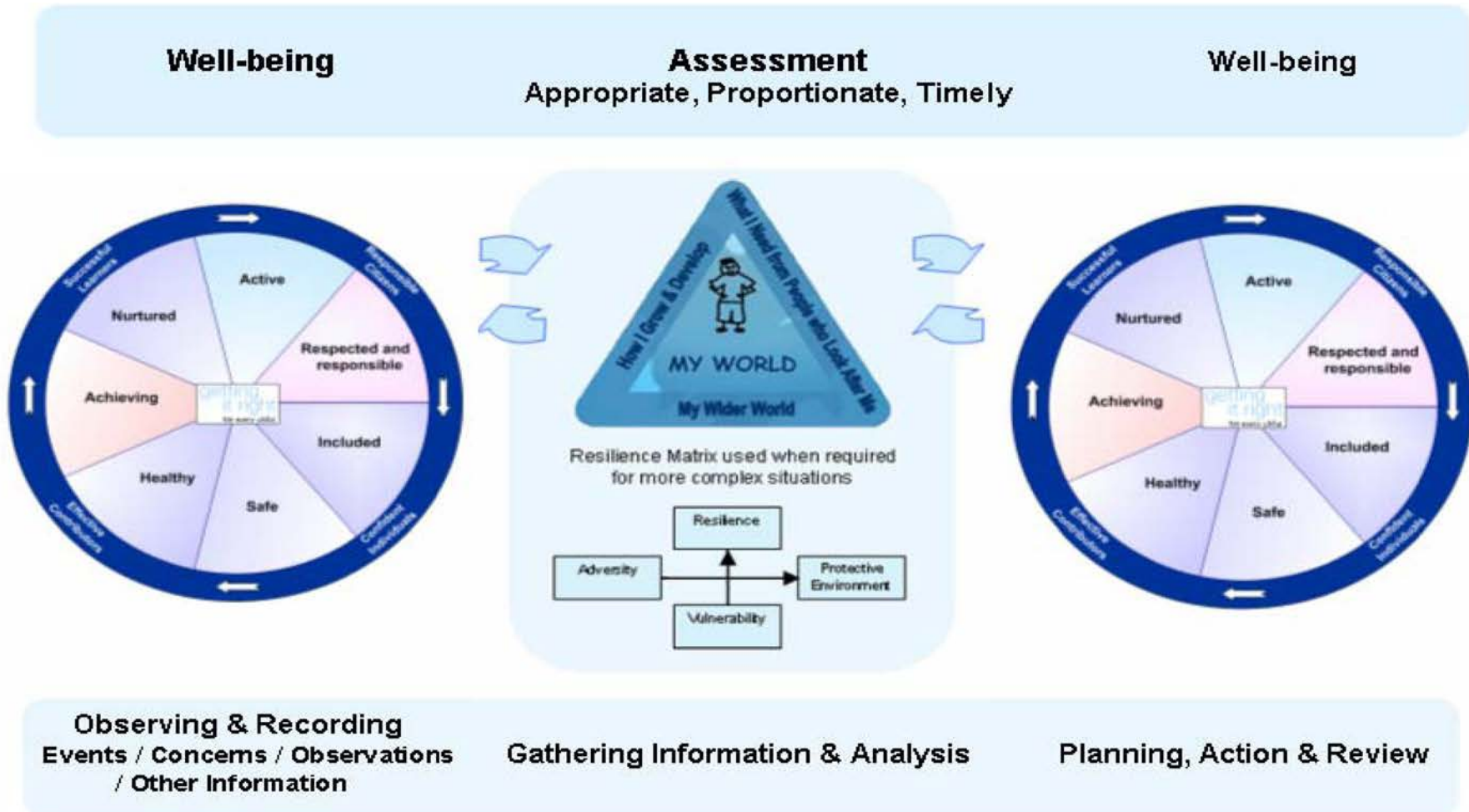
### Girfec Service Delivery Model

Most children will have their needs met within the universal services of health or education as represented in the basic triangle. Some will require additional help within their own service within the remit of the named person. For others with complex needs a multiagency approach requiring an identified Lead professional is needed.





### Appendix 3



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## Appendix 4

### Local and National Policy and Guidance

#### Local

***Breastfeeding Strategy,  
Policies and Guidance  
(NHS Highland)***

Many policies and guidance have been produced to support infant feeding and promotion of breastfeeding in Highland. The range of materials which includes the breastfeeding strategy, breastfeeding policy and other guidance to support best practice can be found on the intranet.

***Child Protection Policy  
Guidelines: Interagency  
Guidelines to Protect  
Children and Young  
People in Highland.  
(Highland Child  
Protection Committee  
2011)***

These guidelines provide a framework for all staff in the Highland Council area who are involved in the safety and wellbeing of children, including unborn babies. They offer an account of the roles and responsibilities of staff from various agencies and promote the need for partnership working using the GIRFEC principles to protect children from abuse and neglect. The standard child concern form is an appendix to these guidelines.

Practitioners in Argyll and Bute will follow the A&B Child Protection Committee Statement of Minimum practice Standards 2008 [www.argyll-bute.gov.uk/abcpc](http://www.argyll-bute.gov.uk/abcpc)

***Domestic Abuse:  
Pregnancy And The  
Early Years Protocol  
(NHS Highland 2010)***

Domestic abuse is a serious health issue and will affect one in four women at some stage in their life. This protocol offers advice primarily to staff who undertake routine enquiry of domestic abuse at booking or provide support to a woman and baby at other stages in pregnancy and during the early years. Pregnancy does not offer any protection for women in abusive situations and the abuse often begins or escalates at this time.

***Highlands Information  
Trail V6 (NHS Highland  
2012)***

This has been produced to support the development of standardised, quality assured services to children and families by detailing the core range of written resources that all parents and carers should receive, at the most appropriate time. It also outlines the Hall 4 implementation programme of screening, surveillance and health promotion.

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***Integrated Children's Plan: For Highland's Children 3 (NHS Highland, Highland Council)***

This third interagency plan confirms Highland's commitment to give every child and young person the best start in life. It is the vision and strategy of the Joint Committee on Children and Young people (JCCYP) and responsibility for implementing and monitoring the plan is the responsibility of all. The role of maternity services is included and describes building the skills and confidence of midwives and public health nurses, maintaining the development of a co-ordinated approach to pre-conceptional health and health during pregnancy and parenthood, implementing the principles of *GIRFEC* and quality assured screening programmes in pregnancy and new born babies.

***Maternal And Child Health Nutrition: Best Practice Guidance (NHS Highland revised 2012)***

These guidelines provide a practical evidence based framework for delivery of nutritional information for use by all agencies who engage with women of child bearing age, pregnant women and children in their early years. They offer a comprehensive package of information that staff will find invaluable in their day-to day work with children and families.

***Perinatal Mental Health: Good Practice Guidelines (NHS Highland 2008)***

Mental health is an issue for us all as it is estimated that one in four people in Scotland will experience problems, often associated with times of stress or changes in our lives. The prevention and treatment of mental health problems in pregnancy and the first year of life is an area where health and social care staff can make a huge difference. These guidelines offer an overview of the extent of the problems and how staff can support women to ensure the best outcomes for women and their families.

***Screening And Surveillance***

There have been recent developments in screening for pregnancy and newborns and more to come. The national screening department of NHS Scotland offers up-to-date information for practitioners and can be accessed at <http://www.nspa.scot.nhs.uk/> Local pathways for pregnancy screening for Down's Syndrome and Neural Tube Defects are available on the intranet.

***Women, Pregnancy And Substance Misuse: Good Practice Guidelines (NHS Highland 2010)***

These guidelines support practitioners when working with women who smoke, drink alcohol or take drugs. They take account of the range of health issues women and babies may face and also how they can be addressed. Staff are also offered advice around the principles of multi-disciplinary and multi-agency working when working with women with complex needs, and the need for assessment of risk for women and their babies.

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## National

***Achieving our Potential: A framework to tackle poverty and income inequality in Scotland (SG 2008)***

This framework to tackle poverty and income inequality in Scotland outlines key actions to be addressed by the Scottish and Local Governments. It describes approaches to reduce income inequalities, introduce longer term measures to tackle poverty and the drivers of low income, support those experiencing or at risk of poverty and make the tax credits and benefits system work better.

***A Framework for Maternity Services in Scotland (SE 2001)***

The Framework is still the key Scottish Policy document for maternity services and is currently being revised to include more detail on current policy direction including addressing health inequalities. It puts midwives at the forefront of early assessment and intervention by working with partners across agencies to improve outcomes for women and their babies.

***Refreshed Framework for Maternity Care in Scotland (SG 2011)***

The refreshed framework builds on the existing framework but also considers a broader approach to addressing health inequalities through the use of a strengths/assets based approach to maternity care, motivational interviewing and behaviour changes approaches.

***Better Health, Better Care: Action Plan (2007)***

The Action Plan describes the need to support people and communities to sustain and improve their health through empowerment and behaviour change. In relation to Maternity services it focuses on the need update the Framework for Maternity Services in Scotland and documents the requirement to strengthen antenatal care to ensure better engagement with families at greater risk of poorer outcomes

***Confidential Enquiry into Maternal and Child Health (CEMACH). Saving Mothers Lives: reviewing maternal deaths to make motherhood safer – 2003-2005***

This report details all maternal deaths in the UK over the period and offers recommendations around practice that may offset these. Although numbers are small, every maternal death is a tragedy and this report offers recommendations to support and improve practice. Most maternal deaths are due to medical or obstetric problems but some are also due to social issues. Access to antenatal care is reported as an important factor in preventing poor outcome and recommendations are made around ensuring services are welcoming and accessible particularly for women who are more difficult to reach. Communication with women and between service providers (GPs, midwives and obstetricians) and true partnership working is imperative for high quality care.

***Newly renamed CMACE***

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### ***Early Years Framework (SG 2008)***

This policy reinforces the need to ensure that all children in Scotland get the best start in life so that by the time they reach adulthood, they are ready to succeed in life despite their background. The ambitions within this relate to breaking the cycle of deprivation through investment in the early years, using the strength of Universal Services to deliver prevention and early intervention strategies, empowering children and families to improve outcomes for themselves and more effective joint working.

### ***Equally Well (SG 2008)***

The report of the ministerial task force on health inequalities includes reference to maternity services and the importance of high quality antenatal care that focuses on early assessment of risk, with interventions put in place that aim to improve outcomes for vulnerable families. It describes the need to improve the quality of interaction between parents, carers and children in the early years through high quality home visiting services and parenting programmes.

### ***Fair Society, Healthy Lives: The Marmot Review (2010)***

This publication contains the findings of a strategic review of health inequalities in England and key messages include the importance of recognising that reducing health inequalities is a matter of social justice. It describes clearly the links between poor health and social class and the need for this to be addressed through the provision of robust universal services that increase in scale and intensity depending on the level of disadvantage experienced by the individual. This is termed as proportionate universalism. The report describes one of the main areas to ensure a reduction in health inequalities is by giving every child the best start in life.

### ***Health For All Children (Hall4)***

The recommendations of Health for All Children, Edition 4 (Hall & Elliman 2003) were implemented in Scotland in 2005. Hall 4 outlines a programme of screening, surveillance and health promotion for children and young people across Scotland and identifies key times when discussion around these issues should take place (Scottish Executive 2005). There has recently been some changes to the programme which reintroduces a 24 – 30 month contact to assess speech, language and communication, personal, social and emotional development – including behaviour, as well as general health, growth and wellbeing.

### ***Healthcare Quality Strategy for NHS Scotland (SG 2010)***

This document strengthens the proposals within BHBC by recognising that improving health begins by improving quality and should therefore be person centred, clinically effective and safe for every person, every time. It describes what people say they want from Health Services and is built around 7 C's – **Caring** and **compassionate** staff and services, **Clear communication** and explanation about conditions and treatment, **Clean** and safe environment, **Continuity** of care, **Clinical** excellence.

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***Keeping  
Childbirth Natural  
and Dynamic  
(KCND)***

KCND is a national programme which promotes pregnancy and childbirth as normal life events. It advocates women centred, community based, midwife led care for healthy women. KCND recommends that each woman will have a named midwife who will take a lead role in their care, working closely with the wider maternity team. Women with complex needs who are in medium or high risk categories should have their care managed by an obstetrician. KCND Pathways for Maternity Care developed by NHS Quality Improvement Scotland provide a tool to aide assessment around medical, obstetric and social risk to ensure all maternity care professionals provide a consistent approach to care for women and babies.

***Midwifery 2020:  
Delivering  
Expectations  
(2010)***

This UK wide document sets out an informed vision of the contribution midwives can make to achieve high quality maternity care now and in the future. The key areas that the work streams focus on: the core role of the midwife, workforce and workload, measuring quality and public health. The document supports the role of the midwife as the key provider of care for women with low risk pregnancies and as the co-ordinator of care within the multi disciplinary team. It discusses how midwives can lead and deliver care in a changing environment and strengthening their contribution as key professionals, to ensure that women, their babies and their partners have a safe and life enhancing experience. It should be used to benchmark midwifery planning and service provision.

***A Pathway of care  
for Vulnerable  
Families, 0-  
3years (SG 2011)***

This guidance was developed to support a joint approach to assessment, care planning and service delivery across agencies focussed on vulnerable families with children – pre-birth to 3 years. It incorporates all national health and social policy that relates to pregnancy and the early years and forms part of the implementation of the Early Years Framework and the implementation of GIRFEC.

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## Appendix 5



### Revised Procedure for

### The Communication and Handover of Health and Social Information Between Midwife and Public Health Nurse/Health Visitor

<b>Policy Reference: 04072012</b>	<b>Date of Issue: June 2012</b>
<b>Prepared by: Sandra Harrington, Midwifery Development Officer</b>	<b>Date of Review: June 2014</b>
<b>Lead Reviewer: Sandra Harrington, Midwifery Development Officer</b>	<b>Version: 3</b>
<b>Ratified by: NMAHP Policy, Procedure &amp; Guideline Ratification Group</b>	<b>Date Ratified:</b>
<b>PFF: completed</b>	<b>Date PFF: June 2012</b>

#### Distribution

- Board Nurse Director
- Head of Health – H&SC
- HOM
- LSA/MO
- Lead Midwives
- Lead Nurses
- Principal Officer Nursing – H&SC
- Midwives
- Public Health Nurse/Health Visitors
- Obstetricians
- GP Sub Group
- Area Managers/ District Managers H&SC
- NMAHP Leadership Group
- Child Protection Action Group

#### Method

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E-mail X

Paper

Intranet x

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The Nursing and Midwifery Council (NMC) states that:

*“Good record keeping is an integral part of nursing and midwifery practice, and is essential to the provision of safe and effective care. It is not an optional extra to be fitted in if circumstances allow.” (NMC 2009:1)*

The NMC guidance also describes that the way information is recorded at key communication points such as at handover, referral and in shared care are crucial (NMC 2009).

‘The Code: Standards of conduct, performance and ethics for nurses and midwives’ (NMC 2008) states that you must:

*“Work with others to protect and promote the health and wellbeing of those in your care, their families and carers, and the wider community”(NMC 2008:1)*

The Code also describes that:

*“As a professional, you are personally accountable for actions and omissions in your practice and must always be able to justify your decisions.” (NMC 2008:1).*

The responsibility of the midwife is to attend a woman and baby for not less than 10 days and for such longer period as is deemed necessary (NMC 2004).

The responsibility of the public health nurse/health visitor (PHN/HV) is to carry out the primary visit between the 11<sup>th</sup> and 15<sup>th</sup> day following the child's birth.

**The purpose of this procedure is to provide practitioners with the guidance necessary to:**

- **Standardise communication and dissemination of information between midwives and PHN/HVs**
- **Provide safe, consistent, timely and effective continuity of care between midwifery and health visiting services**
- **Ensure midwives and PHN/HVs provide an integrated service designed to meet individual needs**
- **Fulfil clinical governance requirements through the implementation of the principles and practices of the Highland Practice Model (GIRFEC)**

This procedure has been developed for midwives working within NHS Highland and PHN/HVs working within The Highland Council. This supports the continuation of the important interface between maternity services and children's services across both sectors.

Planning for Fairness process has been applied to this procedure to ensure equality and diversity

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## Guidelines for Maternity Services Getting it Right for Every Mother & Child

To ensure the above purpose is met, the following procedures and actions must be followed:

1. Each pregnant woman in Highland has a named community midwife (CMW) who is the contact for the family and the named person/midwife for the woman and baby (GIRFEC, KCND). The CMW is responsible for providing and co-ordinating midwifery care in accordance with the NMC midwives rules and standards (2004). Women who require obstetric led care (red pathway, KCND) will still require support and contact from their named CMW.
2. Once the woman has attended maternity services, the PHN/HV will receive the booking summary which informs her of the pregnancy and is the first stage of the communication process between midwives and PHN/HVs. This summary will initiate the public health nursing record and will allow the PHN/HV to plan her antenatal contact (Hall 4) particularly focussing on those women who require additional or intensive support and first time mothers.
3. If there are any changes in circumstances such as moving house or change of name, or continuous risk assessment by the CMW highlights additional or intensive needs that would indicate further support, the PHN/HV must be informed and the details recorded in the mother's notes (SWHMR) and the mother's chronology. This may include any concerns for an antenatal mother missing from a known address (NHS Scotland 2006).
4. Information sharing between midwives and PHN/HVs is a two way process and it may be the PHN/HV who obtains or has knowledge of relevant information about the family which should be shared with the CMW as the named person during pregnancy.
5. Joint visits between CMWs and PHN/HVs should be considered for families requiring intensive provision of care and the PHN/HV should be a partner to the Antenatal Plan. This could occur during pregnancy if needs are identified at this stage and will aid the transition of handover, support best practice and ensure families are included in forward planning of care.
6. When the mother and baby leave hospital following delivery, a copy of the immediate discharge letter which summarises the child birth events, will be sent to the CMW, PHN/HV and GP. In the case of a home birth the CMW will complete the appropriate summary and ensure a copy is sent to the PHN/HV and GP, with a third retained in the midwifery records. This information informs the PHN/HV of the delivery and then allows planning of the new birth visit. Delivery in community midwifery units will be undertaken by the midwifery team and delivery details are relayed within local teams with PHN/HVs and GPs receiving delivery summaries.
7. Each woman and baby has a named PHN/HV who will become the named person for the child at handover. If an area of concern or unmet need has been identified either in the antenatal or postnatal period through the use of the Highland Practice Model (GIRFEC), best practice recommends that face to face contact between midwife and PHN/HV is the ideal method of sharing information and handing over care. If this is not possible, a telephone conversation or equivalent means of communication must take place, the content of which must be recorded in the notes of both midwife and PHN/HV.
8. During the postnatal period most health needs are met by a team approach and there may be occasions where the midwife still has a responsibility to provide extended visits to deliver certain aspects of care. CMWs should discuss these needs with the named PHN/HV to ensure they know when mother and baby are discharged from midwifery care. This will support and facilitate an appropriate plan of co-ordinated care.
9. On discharge from maternity care the named CMW will complete the discharge summary sheets (SWHMR) for both mother and baby and ensure the named PHN/HV has access to the details of this summary. The mother's chronology (where required) will be handed over to the PHN/HV as the named person.
10. The midwife and PHN/HV must record the date of handover in their relevant documentation.

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## References

Highland Children's Services Practice Guidance: Getting It Right for Every Child, 2010

NHS Scotland, Missing Family Alert Protocol, 2006

NMC, Midwives rules and standards, 2004

NMC, Record keeping: Guidance for nurses and midwives, 2009

NMC, The Code: Standards of conduct, performance and ethics for nurses and midwives, 2008

Scottish Government, Keeping Childbirth Natural & Dynamic: Pathways for Maternity Care, 2009

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## Appendix 6

### Getting it Right for Every Child – Maternity Services, NHS Highland Health Plan Indicators - Social Aspects of Maternity Care to support NHS QIS pathways

These indicators serve as a guide for midwives when managing caseloads to assist in allocating women to the appropriate pathway.

All assessments and decisions should be based on individual need and made in discussion with the mother and the wider team as required.

Risk and need may change through the pregnancy journey as will the level of support and contact required.

Green/Core - universal	Amber/Additional – multidisciplinary	Red/Intensive - multiagency
Women receiving universal antenatal and postnatal care with access to their named midwife for advice and support.	Women who may require additional support (including brief intervention and behaviour change approaches) to ensure the best pregnancy outcomes and maintain their own and their babies health and wellbeing.	Women and babies whose health and wellbeing may be significantly impaired and require co-ordinated services to enable them to reach their full potential and maintain their safety and wellbeing.
<ul style="list-style-type: none"> <li>No risk factors or additional needs identified from continuous assessment</li> <li>Woman &amp; health professional agreement with proposed plan of care</li> <li>Knowledge of local support networks and agencies</li> <li>Woman proactive in managing her health and wellbeing</li> <li>Network of social support (family, friends)</li> </ul>	<ul style="list-style-type: none"> <li>Teenage parents</li> <li>Screening issues that require further support</li> <li>Premature/low birth weight baby</li> <li>Mothers recovering from a difficult birth</li> <li>History of antenatal or postnatal depression or mood disorders</li> <li>Poor social networks, social isolation, family breakdown</li> <li>Previous history of child bereavement</li> <li>Families where English is a second language or poor literacy skills/ learning difficulties</li> <li>Temporary accommodation/ poor housing/ travelling families</li> <li>Refugee or asylum seekers</li> <li>Smoking or alcohol use in pregnancy</li> <li>Physical disability or sensory impairment</li> <li>Financial poverty</li> </ul>	<ul style="list-style-type: none"> <li>Domestic abuse</li> <li>Drug and /or alcohol misuse problems</li> <li>Severe and enduring mental health issues</li> <li>Previous child protection issues/involvement with child protection system/ child protection order</li> <li>Significant parental stress</li> <li>Congenital anomalies or chronically sick baby</li> <li>Severe deprivation</li> <li>Homeless families</li> <li>Learning disabilities or health issues that impact on parenting capacity</li> <li>Woman or partner in criminal justice system</li> </ul>

Allocation of HPI's by midwives can assist with caseload management by providing a structured approach to assessment. This supports appropriate, proportionate and timely interventions by determining the impact that these factors may have on mum and baby. It should inform the midwife / health visitor handover and meet the recommendations made within the evaluation of Hall4 across NHS Highland (Feb 2010) and the Child Protection Committee report (June 2009).

Rationale: CEMACH, Equally Well, For Highland's Children 3, Early Years Framework, NHS QIS pathways for maternity care.

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## Appendix 7

### A Pathway of Care for Vulnerable Families: Conception — 3 years



The Scottish Government developed this section and has sought permission for it to be included in the Pathways for Maternity Care.<sup>1</sup> It is intended as a resource to be used alongside critical judgement to support women, children and families who may have an identified additional need.

#### Purpose

There is no fixed definition of 'vulnerability'. The impact that a risk or potential risk factor has on an individual pregnant woman, child or family is dependant on their own life circumstances. Risks rarely exist in isolation, and vary in impact, on outcomes, at different ages and stages across the life course. This tool is to support a common approach to reducing health inequalities in the very early years, conception to age 3. It is not intended as a checklist, but rather an aide memoire to help support clinical practice and judgement when assessing the needs of a pregnant woman, child or family.

#### The Named Person<sup>2</sup>

Most children and young people will get all the help and support they need from their families, the universal services of education and health, and the provision available to everyone within their neighbourhoods and communities. Even so, at various times in their childhood and adolescence, many children and young people will need some extra help that can be provided from universal services. Through children and families knowing who to contact, their access to help is made easier. This is an essential feature of a child centred approach to early intervention. If the child's needs require help from more than one agency, as part of early intervention, the Named Person will take on the role of Lead Professional as a direct progression from the existing support set out in the single agency child's plan, provided this is compatible with their core responsibilities and area of expertise.

- 1 NHS Quality Improvement Scotland. Pathways for maternity care. 2009 [cited 2011 Feb 11]; Available from: [www.nhshealthquality.org/nhsqis/files/Final%20KCND%20pathway\[1\].pdf](http://www.nhshealthquality.org/nhsqis/files/Final%20KCND%20pathway[1].pdf)
- 2 The Scottish Government. GIRFEC practice briefings [online]. 2010 [cited 2011 Feb 10]; Available from: [www.scotland.gov.uk/Topics/People/Young-People/childrenservices/girfec/publications/practicebriefings](http://www.scotland.gov.uk/Topics/People/Young-People/childrenservices/girfec/publications/practicebriefings)
- 3 NICE (2010): Pregnancy and complex social factors. London: NICE

#### Examples of High Risk Groups<sup>3</sup>

- Women misusing substances (drugs and/or alcohol)
- Women experiencing domestic abuse
- Women under 20 years
- Women who are recent migrants, asylum seekers or refugees, or have difficulty reading or speaking English

#### Principles

##### Getting it right for every child (GIRFEC)

- What is getting in the way of this child or young person's well-being?
- Do I have all the information I need to help this child or young person?
- What can I do now to help this child or young person?
- What can my agency do to help this child or young person?
- What additional help, if any, may be needed from others?
- Remember to keep mother and baby in mind.

##### Inequalities sensitive practice

- Be aware of how social circumstances (poverty, disability, domestic abuse) impact on health and health behaviours (smoking, alcohol and drug use)
- Sensitive enquiry into life circumstances
- Empathise- demonstrate this in language and behaviour
- Identify woman's strengths and risks with the woman
- Be aware of health literacy- use teach back

##### Strengths (examples)

- Social networks
- Support/relationship
- Sense of humour/personality
- Motivation

##### Risks (examples)

- Not in supportive relationship
- Own experience – eg abuse
- Depressed or vulnerable emotionally
- Poverty
- Learning difficulty /disability

## Pathway for Vulnerable Families: Conception — 3 years

### Examples of criteria used in maternity services for identifying some of the most vulnerable women and families<sup>4</sup>

#### Substance Misuse

- Alcohol and/or drug misuse in woman and/or partner in last 12 months

#### Blood Borne Virus

- HIV +ve women and/or with a known HIV +ve partner

#### Vulnerable Women

- Significant or current mental health issues (such as bipolar disorder or schizophrenia) impacting on their ability to parent a child and that may lead to child protection issues
- Late booker (over 20 weeks) with additional concerns +/- concealed pregnancy
- Women disengaged from mainstream maternity services (such as recurrent defaulter, or women with difficulties registering with a GP)
- Complex under 16's
- Unaccompanied asylum seeking children
- Mother in care (under 16)
- Gender based violence and/or abuse associated with child protection issues
- Vulnerable adult (eg: learning disability that may lead to difficulty with ability to parent a child and child protection issues)
- Involvement in sex trade/forced prostitution
- Women who conceived in difficult circumstances and/or as a result of rape
- Mother leaving looked after services (16 or over) or working with leaving care services

#### Child Protection Concerns

- Women who have or whose partners have current and/or past involvement with criminal justice system involving child protection issues (eg: Schedule 1 offence)
- Current or previously identified child protection issues (including children previously in care or on Child Protection Register)

#### Asylum Seeker/Refugee

- Disclosure of female genital mutilation (FGM)
- Failed or destitute asylum seekers or illegal entrants
- Women who have been trafficked into UK
- Women who have been victims of torture/imprisonment
- Asylum seeker or refugee with any of the above issues

#### Others to consider

- Homeless families with any of the above issues
- Teenage pregnancy with any of the above issues

### Examples of criteria for identifying children and families potentially requiring additional support form public health nursing services

#### Early Postnatal Additional Needs

- Postnatal depression
- First time parent/s
- Mother's recovering from a difficult delivery
- New babies up to 8 weeks of age
- All children in neonatal unit until completion of SOGS assessment
- Breast feeding mothers depending on need
- Families with 2 or more children depending on need

#### Vulnerable Families

- Families new to area
- Children with isolated, unsupported partner
- Previous history of child bereavement
- Serious illness of parent/child
- Children/parents with complex needs
- Children whose emotional, psychological needs etc
- Children experiencing a crisis likely to result in a breakdown of care arrangements
- Significant life events, for example, bereavement/homelessness
- Children with disabilities including communication disorders.

- Children with complex care needs, chronic ill health or terminal illness.
- Children with emotional, behavioural, developmental or mental health issues
- Families with literacy issues
- Children isolated from services due to geography, resources or parenting capacity
- Children whose development may be affected by a succession of carers
- Specific behavioural problems e.g. sleep difficulties
- Obesity and/or other weight issues
- Children in families where there is poor hygiene
- Children involved in contact/residence disputes
- Failure to thrive/developmental delay

#### Child Protection concerns

- Children on Child Protection Register
- Children recently removed from Child Protection Register
- Children subject to supervision requirement
- Chronology indicating high mobility
- Chronology failed health appointments
- Chronology frequent no access
- Looked after and looked after and accommodated children
- Children experiencing a crisis likely to result in a breakdown of care arrangements

#### Others to consider

- Parents who self refer for additional support
- Young carers

<sup>4</sup> NHS Greater Glasgow and Clyde Women's and Children's Directorate. Special needs in pregnancy: referral criteria [unpublished internal document]. NHS Greater Glasgow and Clyde, [no date]

Appendix 8



Check boxes to highlight sections completed

Section 1 Demographic Detail <input type="checkbox"/>	<a href="#">Section 2 Assessment</a> <input type="checkbox"/>	<a href="#">Section 3 Action Plan</a> <input type="checkbox"/>	<a href="#">Section 4 Review and progress</a> <input type="checkbox"/>
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## Antenatal Plan: additional support for mother and unborn baby

Date of assessment:

Assessment by:

Mother's details

Name:	CHI:
DoB:	First Language:
Age:	Religion:
Expected date of delivery:	Ethnicity:
Home Address:	Telephone;
Postcode:	Mobile;
Midwife/Base:	GP:
PHN/HV/Base:	Obstetrician:

**Preferred method of communication** (e.g. requires an interpreter, prefers contact by mobile phone, etc.)

--

## Guidelines for Maternity Services Getting it Right for Every Mother & Child

**Household members** (Include everyone who lives in the home – partner, any children, relatives, friends, lodgers)

Name	Age/DoB	Relationship to mother

**Other significant people** (e.g. partner, grandparents, relatives, children from previous relationships, friends, children living out-with family home)

Name	Address	Age/DoB	Relationship to mother

**Reasons for the assessment** (Detail of why the plan has been completed. Using the wellbeing indicators (SHANARI) provide an assessment of information gathered from contact with mother, combined with observation and discussion)

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# Guidelines for Maternity Services Getting it Right for Every Mother & Child

<a href="#">Section 1 Demographic Detail</a>	Section 2 Assessment	<a href="#">Section 3 Action Plan</a>	<a href="#">Section 4 Review and progress</a>
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## Section 2: Assessment

**How I grow and develop;** (Mother's views of her health and wellbeing including discussions re: diet, attending appointments, smoking, alcohol/drugs, input from other services)

**Strengths;**

**Pressures;**

**What I need from people who look after me;** (Who does the mother regard as her support network; does she have family and friends to support her; what are the challenges for mother?)

**Strengths;**

**Pressures;**

**My wider world;** (How does the mother describe issues relating to her home, community, work and financial situation?)

**Strengths;**

**Pressures;**



## Guidelines for Maternity Services Getting it Right for Every Mother & Child

**What is the summary of these strengths and pressures?** (Include how the strengths and pressures are impacting on the mother and how they are likely to affect her health and wellbeing, what future impact they may have on her pregnancy and her baby, what does the mother consider as her real concerns and any solutions she may have.)

**Analysis of needs and agreed actions:** (Including any concerns for her and her baby's health and wellbeing, what the mother needs to do to improve outcomes for her and her baby, what support will she be offered to achieve these needs)

## Guidelines for Maternity Services Getting it Right for Every Mother & Child

**Who has contributed to this assessment?** (Include discussions with mother, PHN/HV, ISO, SW, or any other partner supporting mother which may include staff from adult services who are working with the mother or partner.)

**Partners to the Antenatal Plan** (Include mother and any others contributing to the plan)

Name	Role	Address	e-mail	Telephone

**Sharing the Antenatal Plan;** (Mother's agreement to share the plan as detailed below)

**Copy retained in maternity summary?**

Yes ☐ No ☐

**Copy sent to;**

**GP** ☐

Date;

**PHN/HV** ☐

Date;

**Obstetrician** ☐

Copy must be filed in obstetric notes

Date;

**Any others that Antenatal Plan has been shared with?** (Include date sent)

**Chronology attached?**

Yes ☐ No ☐

**Detail any issues around sharing of the Antenatal Plan;**

<a href="#">Section 1 Demographic Detail</a>	<a href="#">Section 2 Assessment</a>	Section 3 Action Plan	<a href="#">Section 4 Review and progress</a>
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## Section 3: Action Plan

### Lead Professional name and contact details

Name;

Job title;

Work address;

Postcode;

Telephone;

Mobile;

e-mail;

### Record of all agreed goals, outcomes and actions

- 1. Goal/long term aim:** (What is the desired outcome for mother - this should reflect the wellbeing indicators (SHANARI). There may be several goals/aims, please number clearly.)

- 2. Evaluating outcome:** (How will we know that the goals/aims have been achieved? Outcomes should reflect change – knowledge, feelings, and skills. Include outcomes words that reflect that change - improve, increase, reduce, decrease, sustain.)

## Guidelines for Maternity Services Getting it Right for Every Mother & Child

- 3. Agreed actions:** (Include activities or services that will be delivered to the mother to improve her situation. Who will deliver the action e.g. children's service worker – early years, family group conferencing, parenting support from voluntary sector partner. There may be several actions – who will undertake them, when are they expected to undertake the action by. Number all.)

- 4. Review arrangements:** (Who will undertake the review, when will it take place, where will it take place e.g. mother's home, how will this action plan be monitored and how will it be reported back?)

**Who;**

**When;**

**Where;**

**How;**

- 5. Mother's view of action plan;** (Is mother happy that the plan meets her needs, clear about who her contacts are and the review arrangements?)

<a href="#">Section 1 Demographic Detail</a>	<a href="#">Section 2 Assessment</a>	<a href="#">Section 3 Action Plan</a>	Section 4 Review and progress
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## Section 4: Review and progress

**Name and designation;**

**Date;**

**Gestation of pregnancy;**

Please complete relevant review section a) or b)

**Review; Have the actions been met?**

**a) No or partially;** (please state)

**No** ☐

**Partially** ☐

**Analysis of impact to date;**

**On-going actions required;**

**How will the plan continue to be monitored?**

**Who;**

**When;**

**Where;**

**How;**

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<b>b) Yes;</b> <input type="checkbox"/>
<b>Summary;</b> (Detail how the outcomes have been achieved.)
<b>Mother's views of outcomes;</b>
<b>Date plan closed and by whom;</b> <b>Name and designation;</b>



## Appendix 9



### Guidance for completing the Antenatal Plan: additional support for mother and unborn baby

#### Introduction

Assessment of risk and need is fundamental when planning care. Enabling health professionals to undertake assessment in the context of the Highland Practice Model (Girfec) will result in a holistic analysis of a child's needs within the structure of their family and the environment in which they live.

The *Child's Plan* is the means of undertaking an integrated assessment for children and forms the basis of any joint working across services or agencies. The difficulty with completing the *Child's Plan* for an unborn baby is that it asks questions of the child which cannot be answered (gender, ethnicity and date of birth).

Maternity services provide support and care to all pregnant mothers through assessing risk and need. It is important that assessment is recorded and analysed in order to ensure that appropriate early support and intervention is in place for the mother well before the baby's birth. Midwives are accountable for the care that they provide and must be able to evidence any decision making including actions and omissions that may impact on outcomes for mother and baby (NMC 2009). The Antenatal Plan supports this approach.

'The Antenatal Plan: additional support for mother and unborn baby' (AN Plan) sets out a consistent and timely process of assessment using the principles of the Highland Practice Model to ensure all children get the best possible start. Analysis of assessment may highlight that additional support can be addressed within health services, nevertheless, the record of that decision making process should still be documented and recorded in the AN Plan (Section 2 - Assessment).

There is an expectation that the AN Plan must be completed for all women who are assessed as requiring an intensive pathway of care to be provided by the multiagency team due to complex social issues. The AN Plan must also be completed for women with additional needs whose situation may be less complex but who still require additional support to be in place to ensure improved outcomes. The completed AN Plan therefore provides evidence of the named midwife's assessment, plan and analysis within the Highland Practice Model and supports best practice and quality assurance.

Section 1 and 2 of the AN Plan may also be used to inform the Integrated Services Officer (ISO) in Highland Councils Health and Social Care, Children's Services of the requirement for resources to be deployed to support additional needs e.g. Children's service worker (early years) to provide parenting support.

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## Aim

The aim of this guidance is to provide maternity staff, usually the named midwife who is undertaking assessment of needs and risks in relation to a mother and her unborn baby, with an outline of how to complete and record the assessment and analysis within the AN Plan: additional support for mother and unborn child.

The assessment may result in the need for another agency to become a partner to a multiagency plan and the AN Plan should be used as that multiagency plan.

The assessment contained within the AN Plan will complement the *Child's Plan* if required following birth or if the case escalates to Child Protection proceedings. If a social worker becomes the Lead Professional then the AN Plan will be used to populate the *Child's Plan*.

Appendix 1 outlines the process for completing the AN Plan.

## Objectives

- To enable maternity staff to undertake assessment for a mother and unborn baby using the Highland Practice Model (GIRFEC)
- To ensure the AN Plan is completed in a consistent way and summarises the assessment, agreed actions, responsibilities and desired outcomes
- To support the data collected in the Scottish Woman Held Maternity Record (SWHMR) by providing a detailed analysis of strengths and pressures for the mother and her unborn child
- To ensure a speedy response when the need for additional resources from another service has been agreed, by the use of a common language and practice framework
- To ensure women are fully involved in the planning of their care

The components to the AN Plan are:

- Section 1 - Demographic detail and reasons for the plan
- Section 2 - Assessment
- Section 3 - Action Plan
- Section 4 - Review and progress

## Completion of the Antenatal Plan

The AN 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 level of detail in the AN Plan should reflect the complexity and analysis of need and it should not require practitioners to spend too much time on its completion. If an area in the AN Plan is not required then it is acceptable to state 'not applicable' to demonstrate that the area has been considered, but is not relevant.

It is not intended that the AN Plan should replace the communication that normally takes place initially by phone between health staff and other services however, the detail of the discussions and decisions that

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take place must be recorded in the AN Plan in order to comply with record keeping advice laid down by the Nursing and Midwifery Council (NMC 2009) and Midwives rules and standards (NMC 2004).

It is intended that the AN Plan should be completed as a Word form to allow expansion of the boxes. It should be stored as a confidential file and when required must be e-mailed across secure networks, marked 'confidential' and requires a reader receipt. Confidentiality can be assured when sharing AN Plans across the NHS and Highland Council email network however, some of the Third sector (voluntary or private) do not use a secure network, and it is important that this is verified prior to sending any Plan. If the AN plan is to be shared with a partner in the Third sector who does not use a secure network the completed AN Plan would need to be printed off and sent by post double enveloped and marked 'confidential' or delivered by hand.

It may be required to re-visit the initial assessment as the pregnancy progresses and to amend the AN Plan. Any additions or changes to the plan must be clearly dated and signed, all partners to the AN Plan informed and a revised copy sent to them as described above.

**Where there are any concerns regarding the safety of an unborn baby, Child Protection procedures must be followed. Staff must ensure they are familiar with these procedures and take appropriate action.**

### Section 1 - Demographic detail

- **Date /Assessment:** when, who and designation of person undertaking the assessment should be recorded.
- **Mother's details:** including current address, phone numbers, G.P., PHN/HV, obstetrician and expected date of delivery.
- **Preferred method of communication:** detail if there are any communication issues such as the need for interpretation services, use of mobile phone rather than home phone.
- **Household members:** this should include everyone who lives in the family home including any other children, relatives, lodgers – even if they are there on a temporary basis.
- **Other significant people:** this should include details of all significant people for the mother including partner, parents, children, children from previous relationships, friends - whether resident or not.
- **Reasons for the assessment:** This section should include a summary of the issues or concerns that have led to the need for the assessment through the use of the wellbeing indicators (safe, healthy, achieving, nurtured, active, respected and responsible, included). This should be informed by details gathered from contact with the mother, observation, discussion or information from another professional.

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## Section 2 - Assessment

### Strengths and pressures identified using the My World Assessment Framework

The use of the My World assessment tool should capture any strengths and pressures that may impact on the mother and her unborn baby. It should detail if appropriate, assessment of the three domains of the triangle and include an analysis of the identified needs and agreed actions. The assessment should be undertaken with the mother and often her words are best used to describe her needs in respect to supporting her health and wellbeing and that of her unborn baby.

The three domains of the My World assessment should consider:

**How I grow and develop:** this should include an analysis of the mother's views of her health and wellbeing, the impact on her pregnancy and baby and identified strengths and pressures

**What I need from people who look after me:** an analysis of the mother's support network, who she feels can support her and any challenges she requires help with.

**My wider world:** this should describe the impact of the social and economic environment on the mother and her baby.

The assessment should include and detail any support provided by the family, input from services within health (e.g. drug and alcohol team, mental health services) and consider whether multiagency input and support is required to address risk and need.

As stated earlier, if any of the three domains in the plan do not require to be addressed, then it is acceptable to state 'not applicable' to demonstrate that the area has been considered, but is not relevant.

Further information about the Highland Practice Model (GIRFEC) is detailed within the 'Highland Pathfinder Guidance'. Clinical work bases should ensure they are familiar with this guidance which is available on the integrated children's services web page <http://www.forhighlandchildren.org/5-practiceguidance/>

**What is the summary of these strengths and pressures:** this should include the impact that the assessment of strengths and pressures will have on the mother, her pregnancy and her baby. It should describe what the mother feels are her concerns and any solutions she may have to address them.

**Analysis of needs and agreed actions:** this section should detail what is required to support the mother and her unborn baby to improve their outcome. This analysis may indicate that provision can be provided within other areas of NHS Highland (mental health services, drug and alcohol teams,) rather than from a partner agency (i.e. local authority, voluntary sector). Nevertheless, the assessment provides evidence of the decision making process and evaluation of risk and need.

**Who has contributed to this assessment?** The mother should be fully included in all discussions and decisions about her care and the details should be documented here together with any other contributions from those who have contributed to the plan.

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**Partners to the Plan:** if the assessment and analysis of need and risk highlights the requirement for several agencies to be involved in the plan then discussion should take place with all of those who will be actively providing care and support to the mother and unborn baby. Their details should be recorded here. This then creates the 'multiagency plan'.

**Sharing the Antenatal Plan:** the mother should be fully involved in the discussions about her care and any decisions made for additional support. The purpose of sharing the detail of the AN Plan should be explained as part of her support for individualised antenatal care.

Information should only be shared proportionately and on a need-to-know basis and the mother should be assured of this. If for any reason the mother does not wish information contained within the AN Plan to be shared with a particular service then this should be detailed. If information is shared without consent, e.g. if there are concerns for the unborn child's safety or that of others, details of with whom and for what reasons should be documented.

Copy of plan retained in Maternity Summary: there is an expectation that a copy of this AN Plan will be retained in the SWHMR Maternity Summary held at base by the named midwife. This will be as a supplement to the SWHMR.

Copy sent to G.P., PHN/HV, obstetrician, any others: the assessment and analysis should be shared as appropriate with the wider maternity team who will be delivering care to the woman and unborn baby. This must include the PHN/HV who will be providing on-going support to mother and baby and should be a partner to any AN Plan. All concerns around need and risk should be discussed with the PHN/HV as detailed in the procedure for handover between midwife and PHN/HV (NHSH 2012). A copy of the AN Plan should always be filed within the obstetric notes.

If any other practitioners or services require this assessment in order to support the mother and contribute to any actions they should be detailed here (e.g. social work, child protection advisor, third sector partners, adult services).

Chronology: If a separate chronology of significant events has been completed for the mother by the named midwife, a copy of this should accompany the AN Plan.

Issues around sharing of the Plan: if there are any reasons that the mother does not wish the AN Plan to be shared with another service then it should be detailed here. The midwife should ensure assessment of the impact this may have and detail it here. Any concerns for the unborn baby's safety or that of others will always override a refusal for information to be shared.

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### Section 3 - Action Plan

**Lead Professional name and contact details:** this section is completed by the named midwife assuming the role of Lead Professional when a multiagency plan is required. It should state the midwife's contact details.

If the decision is made that a social worker is the appropriate person to take on the Lead Professional role in the case of social work taking on this role then the midwife remains the named person and will be a partner to the *Child's Plan* which will be informed by the AN Plan. The AN Plan should state this and be retained in the maternity records.

#### **Record of all agreed goals, outcomes and actions**

The partners to the AN Plan, including the mother, should discuss and decide what the agreed outcomes for her and her baby are and how best to achieve them.

1. Goal/ long term aim: the details of all desired outcomes should be clearly documented and should reflect the wellbeing indicators. There may be several goals/aims and these should be listed
2. Evaluating outcome: how we will know that the goals /aims identified and listed in the AN Plan have been achieved. Outcomes should indicate that positive changes have occurred.
3. Agreed actions: any actions should be proportionate and appropriate to individual circumstances to achieve the desired outcomes and should be agreed and recorded.  
By whom: detail of who will undertake specific roles should be recorded and may include several partners.  
By when: timescales should be agreed and clearly documented.
4. Review arrangements: details of how the plan will be monitored should be agreed including who will review it, when this should occur, the means of review (telephone, meeting) and where it should take place. Any review must ensure that actions are completed timeously – this must be before baby's due date to ensure appropriate early intervention.
5. Mother's view of action plan: ensure mother is in agreement with the AN Plan and she is clear about review arrangements.

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## Section 4 - Review and Progress

Risk and need are dynamic and can change over time therefore the AN Plan may require that more than one review of the initial assessment is undertaken. The detail and progress of the AN Plan should be completed by the Lead Professional who will record whether the actions have been addressed and the outcomes met.

This section should include the name and designation of the person undertaking the review, be dated and the gestation of pregnancy recorded. This person may differ to the original Named Person/ Lead Professional due to rotas, holiday and absence and all caseload responsibilities including review of AN Plans require that management arrangements are in place to ensure effective cover from another member of the team.

### Review: Have the actions been met

#### a) No or partially, please state which:

Analysis of impact to date: an analysis of the progress should be detailed and whether the actions need to be re-considered.

Any ongoing support required: what further support is required to meet the identified needs.

How the plan will be monitored: this should detail who the Lead Professional is monitoring the AN Plan, when this should occur, the means of review (telephone, meeting) and where it should take place.

#### b) Yes

Summary: When the outcomes of the plan have been met, the summary should detail how the outcomes have been achieved.

Mother views of outcomes: the mother should reflect on the support she has been given and the impact it has had and her comments should be recorded. If applicable her partner's views should also be noted.

Date AN Plan closed & by whom: information needs to be recorded

## References

Highland Council & NHS Highland, 2009. *Child's Plan – Health, V8.*

Highland Council & NHS Highland, 2010. *Highland Children's Services Practice Guidance: Getting it Right for every Child.* <http://www.forhighlandchildren.org/5-practiceguidance/>

Highland Council & NHS Highland, 2012. *Revised procedure for the communication and handover of health and social information between midwife and public health nurse/health visitor.*

Nursing and Midwifery Council, 2004. *Midwives rules and standards.*

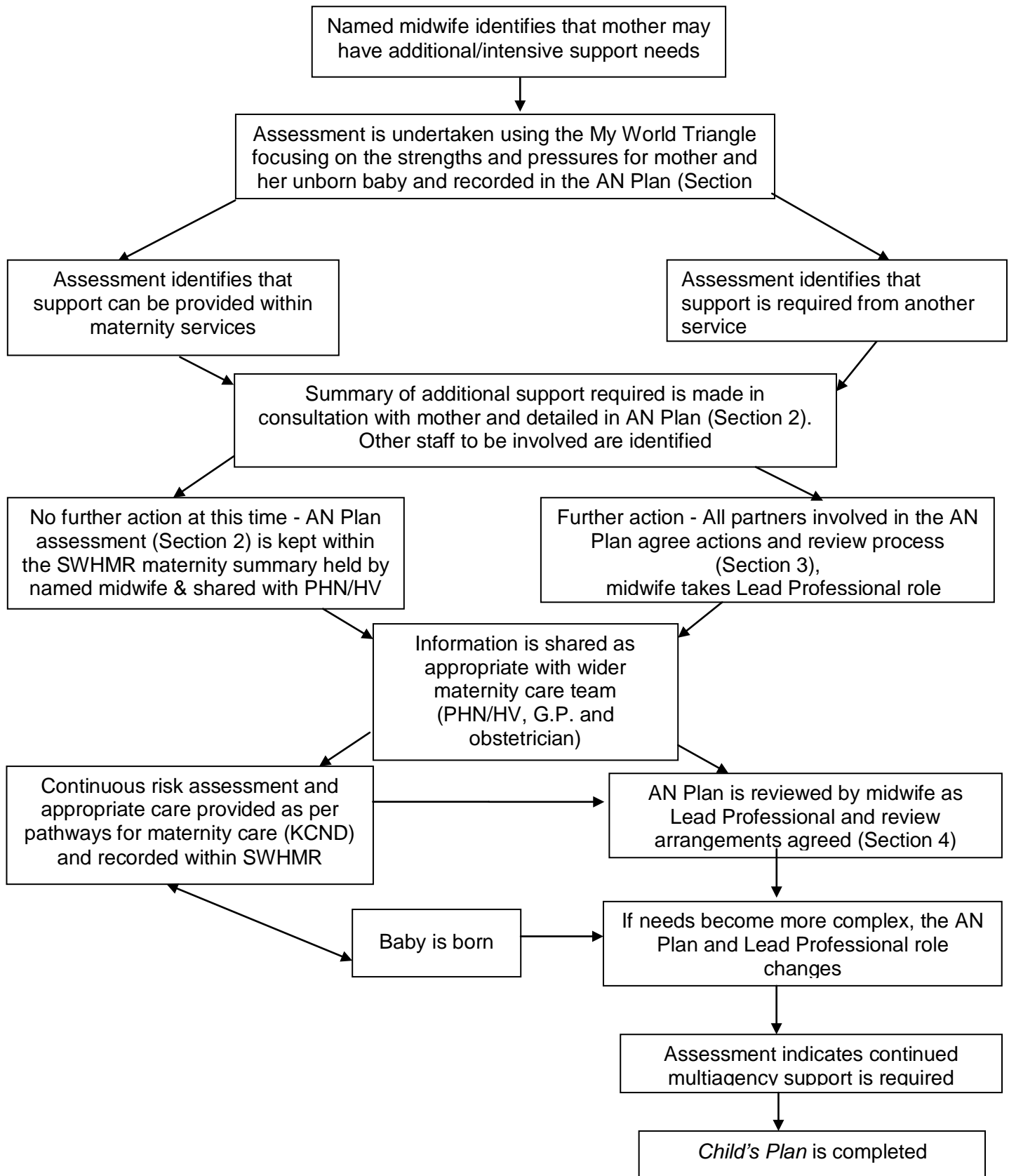
Nursing and Midwifery Council, 2009. *The Code: Standards of conduct, performance and ethics for nurses and midwives.*

Nursing and Midwifery Council, 2009. *Record Keeping: Guidance for nurses and midwives.*

### Use of the Antenatal Plan

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## Guidelines for Maternity Services Getting it Right for Every Mother & Child



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## Appendix 10

<b>MOTHER'S CHRONOLOGY OF SIGNIFICANT EVENTS</b>	Mother's name
	DOB
	CHI
	(OR USE LABEL)

To be completed in the antenatal period until the child is born. Thereafter significant events that impact on the child will be recorded in the child's chronology. Significant events for the Mother may include: non attendance at health appointment, failed appointments, attendance at A/E, or out of hours service, injuries, anonymous referral of concern, request for information due to concern, case conference/meeting, request to other services, change in family dynamics, moving house, housing problems, admissions to maternity units, issues/risks that can make a mother more vulnerable.

Date	Incident/Event	Where Seen	Follow Up (if any and by whom)	Signature

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