States of Jersey

The States of Jersey Department for
Health & Social Services

Family Nursing & Home Care

Joint Protocol for Multi Agency Pre-Birth Assessment and Referral Pathway

DOCUMENT PROFILE

Document Registration	Registration number to be added after ratification
Document Purpose	Protocol
Short Title	Multi-agency pre-birth assessment and referral pathway
Author	Sarah Clarke Paediatric Liaison Health Visitor (version 1) (2013). Michelle Cumming Operational Lead Child and Family Service (FNHC) reviewed version June (2016). Developed through working group: Julie Mycock Acting Lead for Maternity Services Elizabeth Plastow Designated Nurse for Safeguarding Kathy Palmer Midwife (MW) Giselle Camm Midwife Rhonda Hales Midwife Marie Raleigh Health Visitor (HV) Glynis Collier Paediatric Liaison Health Visitor (PLHV) Laura Hill Social Worker (SW) Dr Nigel Minihane GP, Chair PCB Dr Philippa Venn GP, Vice Chair PCB Dr Sarah Whiteman Medical Director & Responsible Officer, Primary Care
Publication Date	
Target Audience	Division of Women & Children, Midwives, Health Visitors, Social Workers, General Practitioners
Circulation List	Julie Mycock, Elizabeth Plastow ,Mark Jones, Julie Gafoor, Sally Gebhardt, Julia Wise St Léger Fon Roberts, Rhonda Hales, Kathy Palmer, Giselle Camm, Michelle Cumming, Ann Trotter, Judy Foglia.
Description	Joint working protocol to promote early recognition of concerns to enable a timely and appropriate plan of care to be put in place to safeguard the welfare of the unborn and family
Linked Policies	
Approval Route	Hospital Care Quality Group / Community Care Quality Group / Integrated Governance Committee
Review Date	1/ 3 / 5 years from approval
Contact Details	

REGISTRATION NUMBER

CONTENTS LIST:

1. INTRODUCTION

Child Protection Serious Case Reviews and the Williamson Report (Jersey HSS 2008) have highlighted the need for all health and social care professionals to share information, improve communication pathways and maintain accurate, contemporaneous records. 'Ages of Concern: learning from serious case reviews' (SCR's) (Ofsted 2011) highlighted that 35% of SCR's were on babies under 1 year and health were the most frequent agency involved with babies.

Midwives are ideally placed to initiate the communication pathway when a woman presents for antenatal care in pregnancy, however, developing and maintaining good communication pathways is the responsibility of all health and social care professionals and not solely reliant on one discipline.

Early recognition of concerns enables a timely, appropriate plan of care to be put in place, safeguarding the welfare of the mother and child.

'Working Together to Safeguard Children' (2015) highlighted that "those health professionals who work with children; young people and families…as part of generally safeguarding children and young people, provide ongoing promotional and preventative support, through proactive work with children, families and expectant parents".

1.1 SCOPE

This protocol covers Midwives, Health Visitors, GPs and Social Workers and it will be agreed by Jersey Health and Social Services Department and Family Nursing & Home Care.

This protocol covers the procedure for sharing of health and social factors affecting the family and safeguarding of the mother, unborn and new born child. Pre-birth assessment, identification of need and referral pathway to relevant Professional or agency.

This protocol does **NOT** replace existing Jersey Safeguarding Partnership Board Multi - Agency Child Protection Procedures (2015). This is additional guidance to promote effective partnership working- Working Together (HM Government, 2015).

2. GUIDELINE PURPOSE

This protocol aims to:

- Safeguard babies and children by ensuring two-way communication of relevant information and concerns between acute and community healthcare professionals and social workers in a timely fashion.
- Outline clearly the responsibility of professionals during pregnancy, optimising the outcomes for babies and children.
- Provide a robust, standardised antenatal communication and joint assessment pathway for all professionals to use.

- Provide and maintain high quality holistic care to expectant mothers and their baby before, during and after birth.
- Enable health and social care professionals to provide an individual care plan for each family; based on assessment and the shared information about the health and environmental factors affecting the family.
- Promote ongoing collaboration, assessment and care plan review by all professionals involved with the family.
- Ensure relevant information is shared between professionals with the mother's knowledge and agreement. If consent is refused and there are actual or potential risks of significant harm to mother or baby, sharing should go ahead. The principle record is held on EMIS and is shared via sharing protocols. In addition, records are held on TRAKCare HSS.
- Consider relevant health and social history that could impact on the health of mother and baby.

3. PROCEDURE

3.1 General

This procedure is outlined in the flowchart in Appendix 1.

All Midwives should make a formal health and social wellbeing risk assessment at booking. The information obtained is dependent on the information provided by the woman. A joint Health needs Assessment (appendix 3) should be commenced at booking, be handed over to the Health Visitor by 28 weeks and continued until 4 weeks postnatal then closed. Any significant factors are shared with midwife and GP until midwifery discharge of client.

The General Practitioner (GP) should be informed of pregnancy and any identified needs or risks, if not already aware. Client's first point of contact is commonly the GP and prior to the booking contact with midwife.

A referral to the Health Visitor (HV) should be made by the Midwife or GP after assessment if there are concerns. See Appendix 2; Recommendations for referral. **This may include consideration for MECSH.** (Maternal Early Childhood Sustained Home Visiting, the University of New South Wales 2011). On receipt of the referral it is the responsibility of the Health Visitor to review their records pertaining to the family and at the earliest opportunity share any information with the Midwife which could impact on the welfare of the mother and unborn and the safety of professionals. The MW/HV may also obtain information from the GP Consent to share information between professionals should always be obtained from the mother, indicating that this sharing will not only be with the Midwifery service, but shared between other professionals on a needs to know basis. If consent is not given, Child Protection Procedures should be followed. Verification of consent should be recorded in the Maternity Records. The HV/MW/Paediatric Liaison Health Visitor (PLHV) is responsible for obtaining relevant information from the GP and seeking their consent to share across partners.

If HVs are aware of any other relevant health or social history pertaining to the mother this should be communicated to the Midwife and the Paediatric Liaison

Health Visitor (PLHV). Sharing of information should also occur at midwifery to Health Visitor information shared by 28 weeks gestation and including GP.

If the HV are aware of any relevant health or social history pertaining to the mother's partner/wider family, consideration should be given to how this is communicated. This would involve assessing the issue / potential risk and whether the issue is serious enough to be shared. Consideration should be given as to whether to ask consent from the partner to share information or whether asking consent might put the mother at increased risk.

If there are any difficulties then support should be sought from the child protection named nurse, Designated Nurse or Designated doctor or senior midwife in the hospital.

For every pregnancy regardless of level of concerns.

- Follow Department of Health pathway (Appendix 2) for handover of clients to HV service and using the joint Health Needs Assessment (HNA) as core information for this handover.
- All professionals involved with the family have a responsibility for ongoing communication and collaborative working.
- Professionals must update each other with any changes in the mother's contact details. This can either be directly on the EMIS system or as a secure email.

3.2 Levels of Concern

Please refer to Safeguarding Partnership Board Multi-Agency Child Protection Procedures and associated threshold criteria/Continuum of need.

3.2.1 No Concern (Universal)

- Where no concerns have been identified at booking, the Midwife is responsible for an ongoing health and social needs assessment throughout the pregnancy. The joint Health Needs Assessment will commence at booking with the midwife. Where the woman chooses to see only her GP or Consultant (privately arranged care) then the responsibility to share identified health and social needs lies with that medical practitioner so that continuous care is enabled.
- The Health Visitor is responsible for making contact via letter by 28 weeks gestation, inviting a face to face contact and home visit, wherever possible. Full contact details for the team should be included in this letter to the parent.
- The midwife, GP, Consultant should be informed of the relevant Health Visiting Team

3.2.2 Low Level Concerns (Universal plus)

- If concerns are identified by any health or social care professional the information **must** be shared on a needs to know basis with the all relevant professionals, and referrals for support made as appropriate. Consent

should always be sought where necessary. If consent is refused then only share if mother or unborn/infant is at risk of harm.

- The Midwife should liaise with the Health Visitor to discuss whether a joint home visit should occur in the antenatal period. The discussion and outcome must be documented by the Midwife on TrakCare (HSS IT system) and by the Health Visitor in the FNHC Record in EMIS.
- A supportive package should be negotiated with the mother and with the involvement of other professionals and services e.g. Brighter Futures, NSPCC, Pathways Child and Family Centre, Samares School. Where required and documented in the professional's records.
- Consideration should be given to Early Help assessment. earlyhelp@gov.je
- Escalating concerns should be forwarded to Children Social Services and MASH (Multi Agency Safeguarding Hub) (Follow enquiry to children's services pathway under medium to high level of concern; Appendix 1). **https://safeguarding.je/multi-agency-safeguarding-hub-mash/**
- A multidisciplinary team planning meeting may be arranged by the midwifery service followed by pre-birth risk assessment if thresholds are reached or if there is an escalation of concerns .These should be carried out within the second trimester.
- Midwives/Health Visitors should be involved with this planning process at any point that they occur including before 28 week handover from midwife.
- BY 28 weeks gestation the Health Visitor must complete the Antenatal contact letter unless face to face contact has already been made.

3.2.3 Medium / High Level Concerns (Universal Partnership Plus)

When a medium or high level of concern is identified (regardless of gestation) the Midwife should seek any additional information from the Health Visitor and GP. The Midwife should then have a consultation with either their Named Nurse for safeguarding, Designated Nurse/Doctor or with Children Social Services, and complete a written enquiry form to MASH following Child Protection Policy and Procedures (Follow referral to children's services pathway under medium to high level of concern; Appendix 1). MASH then feedback outcome of the enquiry to the referrer who must in turn share with practitioners involved with the client. MASH enquiry should be made at the earliest opportunity, preferably by 14 weeks gestation to allow for early intervention and intensive support.

In these cases Midwives and HV's must access safeguarding supervision .If there is professional disagreement regarding the decisions made this should be recorded in the records, including the reasons for disagreement, and discussed at the 6 weekly multidisciplinary team (MDT) meetings. The Safeguarding Escalation policy may be utilised where necessary.

A pre-birth planning meeting may be arranged by Children's Service followed by pre-birth risk assessment by Children's Social Services. This should be held in the second trimester to allow enough time for a pre-birth Initial Child Protection Case Conference early in 3rd trimester, a Child Protection plan to be put in place for the unborn child and the first Core Group to be held prior to the birth.

All professionals involved with the family have a responsibility for ongoing communication and collaborative working; to facilitate this, 4 weekly MDT meetings should be held with Midwifery, Paediatric Liaison Health Visitor (PLHV), Children's Service, Drug and Alcohol Service.

If there are serious drug or alcohol concerns a medical pre-birth meeting should be held at 32 weeks with parents, midwifery, paediatricians, PLHV, HV, drug and alcohol service and SCBU. This should be arranged by midwifery services.

The Midwife may arrange a joint home visit with the Health Visitor and the outcome of the visit will be documented on Trakcare by the Midwife and in the FNHC record by the Health Visitor (EMIS). If this is not possible to arrange, the Health Visitor should arrange a home visit with the parents. HV/MW should keep the mothers' GP informed of the plan of care.

3.3 POST NATAL PERIOD

The Midwife must complete pages 3 and 4 of the Personal Child Health Record (Red Book) in the early postnatal period for all babies. Where new concerns are identified this must be shared with the Health Visitor or PLHV and GP. This must be documented and a plan of care agreed based upon the joint Health Needs Assess.

Discharge letters from the hospital will be generated by Trakcare and sent to the HV via the Child Health Department. Discharge letters from the community midwives will be sent to the HV teams as soon as possible after discharge.

3.4 TRANSFER OF CARE TO THE HEALTH VISITING SERVICE

It is best practice to ensure relevant information is shared between professionals, with the mother's knowledge and agreement/consent. The joint HNA will facilitate this.

The Midwife must share any additional health or wellbeing concerns regarding the mother, baby or family with the Health Visitor on or before the tenth day following delivery and this must be documented by the Health Visitor in the client's FNHC Record.

The Health Visiting Team will contact the mother to arrange a New Birth Visit. All new mothers will have a New Birth Visit by 14 days postnatal unless negotiated with the family (contact on Special Care Baby Unit if baby still in hospital care). This follows the 'Healthy Child Programme' (DoH 2009). For all new mothers this visit will be completed by 28 days after the birth and documented in the FNHC Record.

In some cases the Midwife may continue to visit for longer (up to 28 days) depending on the vulnerability of the family and this will be agreed in partnership with the Health Visitor.

4. DEVELOPMENT AND CONSULTATION PROCESS

Name and Title of Individual	Date Consulted
Julie Mycock – Head of Midwifery	
Kathy Palmer - Midwife The Bridge	
Rose Naylor - Chief Nurse	
Giselle Camm - Midwife Antenatal Clinic	
Mark Jones - Paediatrician	
Akin Famoriyo - Obstetrician & Gynaecologist	
Helen Jackson - Children's Social Services	
Judy Foglia FNHC - Governance	
Sarah Clarke - Health Visitor FNHC	
Jenny Querns - Health Visitor FNHC	
Greg MacDonald - MASH Children's Service	
Fiona Clough - HV team lead FNHC	
Sarah Whiteman - Medical Director and responsible officer, Primary Care	
Ann Morgan - Lead Nurse for Children HSS	
Nigel Minihane - Chair Primary Care Body and Philippa Venn Vice Chair Primary Care Body	
Linzi Gilmour - Named Nurse safeguarding JGH	

Name of Committee/Group	Date of Committee/Group meeting
FNHC Policy and Procedural document meeting	
Women and Children's Divisional Meeting	
Hospital Care Quality Group	
Senior Health Professionals Safeguarding Group	
Social Care Management Meeting	

5. REFERENCE DOCUMENTS

Department of Health (2009) Healthy Child Programme; Pregnancy and the first year of life.

HM Government (2015) Working *Together to Safeguard Children: A guide to interagency working to safeguard and promote the welfare of children* London: The Stationary Office
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419595/Working_Together_to_Safeguard_Children.pdf

Jersey Safeguarding Partnership Board. Jersey Safeguarding Partnership Board Child Protection Procedures (2015).
http://jerseyscb.proceduresonline.com/

Jersey Health and Social Services (June 2008). The Williamson Report: An Inquiry in to Child Protection in Jersey

Ofsted's evaluation of SCR's from April 2007 – March 2011

Ofsted (2011) Ages of Concern: learning from serious case reviews (SCR's).

The University of New South Wales Research Centre for Primary Health Care and Equity (2011) MECSH Maternal Early Childhood Sustained Home – visiting

West Sussex Local Safeguarding Children Board. Child Protection good practice guide. Concealed pregnancy and Birth 2007

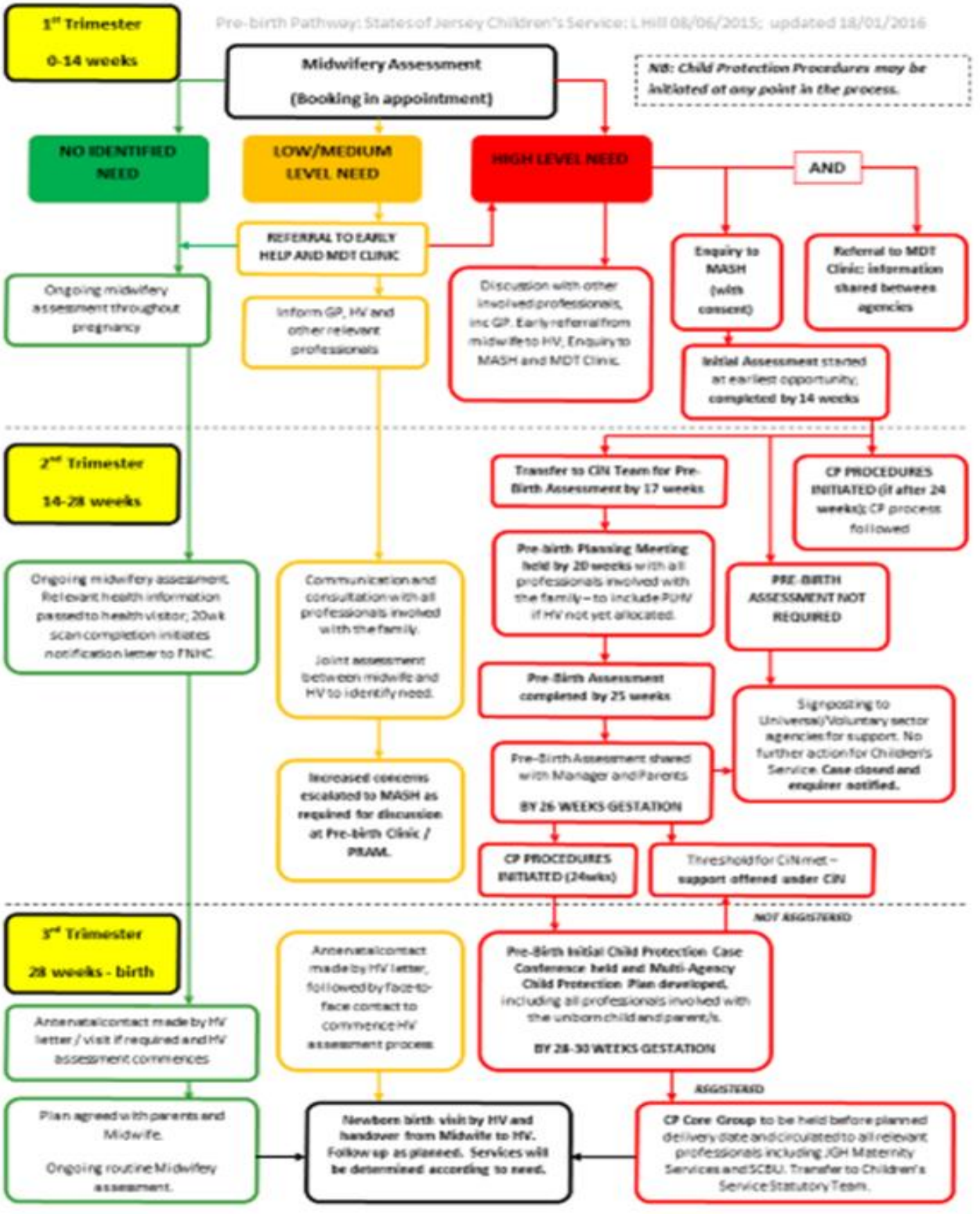
Acknowledgements to:
Northern Health and Social Care Trust
Eastern and Coastal Kent Community Health NHS Trust
Swindon local Safeguarding Children Board

6. IMPLEMENTATION PLAN

A summary of how the policy will be implemented – use of a table such as that below is often helpful.

Action	Responsible Officer	Timeframe
To disseminate to Midwives at band 6 meeting.	Julie Mycock/Kathy Palmer	
Band 6 midwives to roll out to team members	Band 6 Midwives	Within 1 month of ratification
To disseminate to Health Visitors at meeting.	Michelle Cumming	
Designated Nurse for Safeguarding to share at Strategic level - SPB, MASH	Elizabeth Plastow	Within 1 Month of ratification
To disseminate to GPs via PCB		

Appendix 1 - Prebirth Pathway for Social Work



APPENDIX 2 — Department of Health Pathway

	ANTENATAL							POSTNATAL	
When	Booking in (8-12 weeks)		16-28 Weeks		32-36 Weeks			Birth visit to 10-14 days	
Who	Midwife	HV	Midwife	Midwife/HV	Midwife	Midwife/HV		Midwife	Midwife/HV
Where	Home, Health Centre, Children's Centre, GP Surgery – dependent on family need and local provision							Obstetric/Midwifery Unit/Home	Home
Action	Antenatal screening. There is a need to address the consent issues of the mother and father for further notification. There needs to be recognition that the midwife is responsible for the mother, unborn child and father during the antenatal period and is responsible for ensuring all appropriate services are in place. Midwifery team to notify HV team of pregnancy, and MECSH if appropriate. Notification to include assessment of need, including needs of the father, and referrals to other agencies and action plan. This should be a particular consideration for women and fathers with complex social factors (NICE 110). 12 weeks health needs assessment.	Health Visitor/health visiting Team to inform midwife of named health visitor for every woman.	Ongoing review of action plan. Midwife to communicate any change in the pregnancy status and/or changes in risk to the family or child to the named HV/HV Team. Health Promotion Review. Midwifery team to notify HV within one working day of any significant changes to maternal or child wellbeing, for example, miscarriage, still birth, congenital abnormality, serious illnesses and admission to NICU.	Possible further health needs assessment, including father's needs. Where a woman or father is identified as vulnerable the midwife and named HV should work collaboratively to assess the needs of the woman and it is recommended that they consider a joint meeting with the family (NICE 110). Antenatal letter to be sent by 28 weeks gestation.	Birth Plan, including father's needs and place of birth. Shared with HV. Postnatal care choices and needs. Midwifery team to notify HV within one working day of any significant changes to maternal or child wellbeing, for example, miscarriage, still birth, congenital abnormality, serious illnesses and admission to NICU. Coping with Crying video/clip to be used universally at antenatal visits as part of standard operating procedure.	HV universal contact. Supported emotional transition to parenthood in vulnerable groups. Offer of a holistic assessment of unborn child and family risk and resilience factors, using a strengths-based partnership approach to support transition to parenthood, if appropriate (the timing of this is variable between trusts but should be completed pre-birth) Women with identified vulnerability (e.g. maternal mental health, learning disability, foetal development issues, obstetric issues, domestic violence etc.) or need to have received an 'individualised postnatal care plan' prepared in conjunction with midwife and HV (NICE 37)	Midwife to update the HV on the health and social status of both mother and baby. Midwife to explain to all women the purpose of the parent-held personal child health record and how it will be used by midwife and HV (NICE 37). Day 5-7 midwife to complete appropriate sections of the parent held personal child health record to facilitate handover to the HV. Midwifery team to notify HV within one working day of any significant changes to maternal or child wellbeing i.e. still birth, congenital abnormality, serious illnesses and admission to NICU.	Child and family needs assessment, including father's needs. It is recommended that by day 14 all women, particularly those with identified vulnerability or need, have received a joint handover/contact visit with their midwife and HV, it is recommended that this be a home visit. At discharge of vulnerable women and women who require midwifery input after day 14, the midwife and HV to have completed and recorded a verbal handover in addition to a written handover (NICE 37).
HCP Key messages and actions	• Promoting the health and emotional wellbeing of the mother • Promoting positive mental health of the mother • Promoting vitamin for all women • Preparing families for transition to parenthood • Promoting breastfeeding and the support available • Promoting the importance of the involvement of the father. • Promoting the neurological development of child, the negative impact of stress and the importance of attachment. • The Health Child Programme also promotes good liaison between midwife and HV to benefit early intervention.		• Promoting the health and emotional wellbeing of the mother • Promoting positive mental health of the mother • Providing information on local Children's Centre services and consent to contact. • Providing smoking cessation support. • Promoting breastfeeding and the support available. • Providing information on screening and immunisations, child development, maternal nutrition e.g. folic acid and other dietary or lifestyle advice as required. • Preparing families for transition to parenthood. • Promoting the importance of the involvement of the father.		• Promoting the health and emotional wellbeing of the mother • Promoting positive mental health of the mother • Preparing families for transition to parenthood. • Promoting the importance of parent and baby mental health/attachment. • Providing safe infant feeding information. • Promoting breastfeeding and the support available. • Signposting parents to Parent Education. • Promoting the importance of the involvement of the father. • Delivering the Pregnancy, Birth and Beyond programme in partnership.		BIRTH	• Providing safe infant feeding information. • Promoting breastfeeding and the support available. • Observing and promoting the importance of parent and baby mental health/attachment. • Promoting attuned, sensitive parenting that supports the baby's early development and positive mental health. • Assessing maternal mental health. • Promoting the importance of father/partner involvement. • Supporting mother with postnatal exercise. • Promoting home safety. • Promoting steps to take to prevent Sudden Infant Death Syndrome (SIDS). • Providing information on smoking cessation, development and growth. • Providing information on, and registration with, local Children's Centres. • Delivering the Preparation for Birth and Beyond programme in partnership.	
Your Community	Targeted to meet the identified needs of the community. Your community has a range of services including some Sure Start services and the services families and communities provide for themselves. HV's and midwives work together to develop and promote community based support for expectant and new parents, such as transition to parenthood groups and activities that meet the needs of local families.								
Universal Services	Universal Services are for all families. Health visitors deliver the Health Child Programme to ensure a healthy start for children and families, for example immunisations, health and development checks, support for parents and access to a range of community services and resources.								
Universal Plus	Targeted according to assessed or expressed need, universal plus gives a rapid response from the health visiting team when families need specific expert help, for example with postnatal depression, a sleepless baby or answering any concerns about parenting.								
Universal Partnership Plus	Targeted according to identified need. Universal partnership plus provides ongoing support from the team plus a range of local services working together with families to deal with more complex issues over a period of time. These include services from Sure Start Children's Centres, other community services including charities and, where appropriate, the family Nurse Partnership.								

APPENDIX 3

Health Needs Assessment

Personal/Social

1) Do you have any problems with communications? e.g. Dyslexia, literacy problems or a need to use sign language

Yes ☐ No ☐

If yes, please specify**…….....**

Ethnic group		
	Code	
White	A	White British
	B	White Irish
	C1	White French
	C2	White Polish
	C3	White Portuguese
	A1	White Jersey
	C	Other White background
Mixed	D	Mixed White / Black Caribbean
	E	Mixed White / Black African
	F	Mixed White / Asian
	G	Other Mixed background
Asian / Asian British	H	Asian / Asian British - Indian
	J	Asian / Asian British – Pakistani
	K	Asian / Asian British – Bangladeshi
	L1	Asian / Asian British - Thai
	L	Asian / Asian British – Any other background
Black or British Black	M	Black / Black British – Caribbean
	N	Black / Black British – African
	P	Black / Black British – Other background
Chinese	R	Chinese
Other	S	Other ethnic group

2) a) What is your age? **…….**

b) What is your partner's age? **…….**

3) a) What is your marital status?

Married Stable relationship

Single Separated

Widowed Divorced

b) Do you live together?

.....

c) How long have you been together?

.....

d) In your household is there a: Step parent? Cohabitee?

.....

4) Number and ages of children?

.....

.....

5) a) Have you recently moved into the area?

Yes ☐ No ☐

b) Have you any family support nearby?

.....

c) Do you feel isolated socially, emotionally or geographically?

.....

.....

6) Have you any problems with housing? If yes, please specify:

.....

.....

7) Are you are your partner under financial stress or unemployed?

.....

.....

Physical Health

8) Does any member of your household/family have a medical condition or disability?

Yes ☐ No ☐

If YES, please specify

.....

9) Does anyone in the family have dietary problems?

Yes ☐ No ☐

If YES, please specify

……...

……...

10) a) Is there anyone in the house who smokes?

Mother Father Significant other

b) Brief intervention offered to persons present?

Yes ☐ No ☐

11) a) How many units of alcohol do you and your partner consume on average per week?

Mother**: ……** Father**: ……**

b) Do you or your partner use drugs (or have in the past) – prescribed or recreational?

……...

……...

c) Do you or your partner receive support or treatment for a drug or alcohol related problem?

……...

……...

Mental and Emotional Health

12) a) Describe your emotional health/well-being at present - Ask WHOOLEY Questions

……...

……...

b) Is there anything currently worrying you? If YES, please specify

……..

……..

13) a) Have you ever been depressed or suffered from a mental health illness?

……...

……...

b) Have you ever suffered with post-natal depression?

……...

……...

c) Has your mother ever suffered with postnatal depression?

……...

……...

d) Have you ever thought of harming yourself?

……...

……...

e) Has your partner ever been depressed or suffered a mental illness?

……...

……...

14) Are you or your partner receiving any professional support? If YES, please specify

……...

……...

15) **<u>Only ask if appropriate/safe to do so</u>**

Some women tell me their partners are cruel. Have you ever been in a relationship where you have been hurt physically, mentally or emotionally?

Past:…… Present:……

(Other examples to explain mental or emotional abuse could include; being denied access to friends or family, not being allowed own money, threats of violence or forced to have sex etc.)

16) Do you or your partner have any history of police/youth offending team/probationary involvement?

……...

Previous Children

17) History of previous pregnancy

……...

……...

18) a) Were there complications during or after the birth of your baby? e.g. Multiple birth, prematurity, low birth weight or any separation

……...

……...

19) Have any of your children received or are receiving ongoing hospital treatments?

……...

……...

20) Have any of your children any special needs or developmental delay?

……...

……...

21) Have any of your children any sleep, toileting or behaviour problems which concern you?

If YES, please specify:

……...

……...

22) a) Have you or any of your children ever been allocated a social worker?

……...

……...

b) Have any of your children been subject to a child protection or child in need plan?

……...

……...

Ante Natal

23) How do you feel about attending for ante natal care?

……....

24) a) Is this the first child for you and your partner?

……

……

b) is this a multiple pregnancy?

……

……

25) Have you ever had fertility problems?

……

……

26) a) How do you feel about this pregnancy?

……

……

b) How does your partner feel about this pregnancy?

……

……

Experience of Childhood and Family Life

Mother

27) How do you think your own childhood and experience of being parented will impact upon your own approach to parenting?

……

……

Father

28) How do you think your own childhood and experience of being parented will impact upon your own approach to parenting?

……

……

Support

29) Who supports you and your family?

……...

……...

Safeguarding Assessment

30) Are there any legal or formal arrangements regarding access/access restrictions to your child?

Yes ☐ No ☐ N/A ☐

31) Are there any issues with alcohol misuse with any individual living within your child's home or with any other adult that has direct supervision of your child?

Yes ☐ No ☐

32) Are there any issues with drug misuse with any individual living within your child's home or with any other adult that has direct supervision of your child?

Yes ☐ No ☐ Not asked ☐

33) Are there, or have there been, any issues with domestic violence within your child's home or with any other adult that has direct supervision of your child?

Yes ☐ No ☐

<u>Action Plan for future care</u>

……

……

……

Action Plan recorded in records

Professional details:

Date: ……/……/……

Time: ……

Name: ……

Designation: ……