University Hospitals Plymouth NHS Trust

Freedom of Information Act Disclosure log - Reply Extract

File reference	W21FOI224
Key words	Clinical Guidance on Maternity Care Involving Surrogacy and Intended Parents
Date of release	05/08/2021
Attachments	No

You asked

Do you have any clinical guidance regarding the maternity care of women involved in surrogacy and/or the intended parents?

If so, are you able to provide me with a copy, to see what aspects of care are covered?

Our reply:

Please see the attachment.

Attachments included: No

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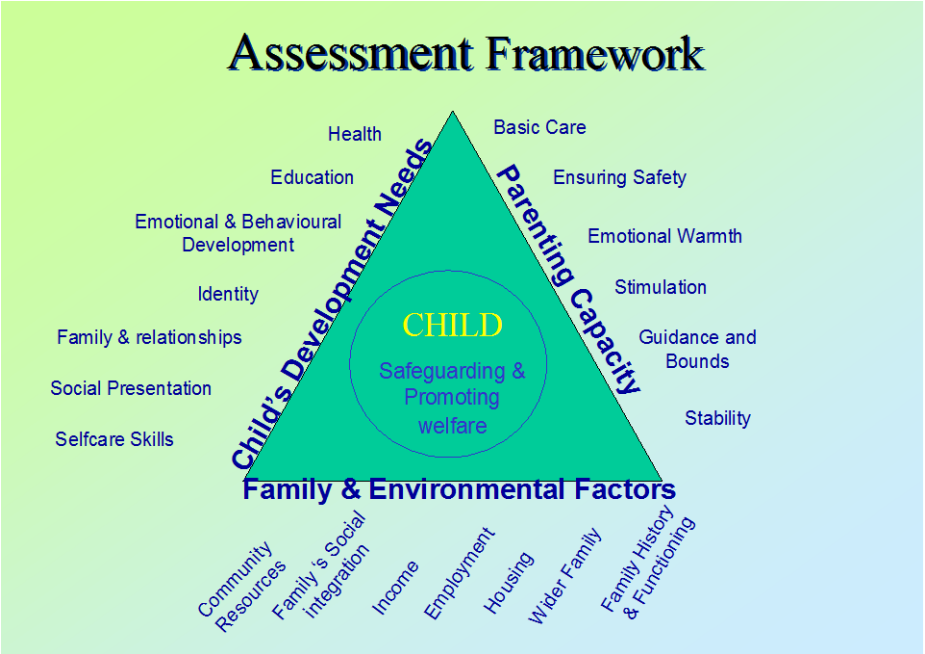
MATERNITY GUIDELINES

Safeguarding Pathway

Navigation
Guidance document – in the contents page the Press Ctrl on your keyboard and click on a heading to navigate to that section in this document.

Introduction

The underpinning of this guideline is based on the Children's Act 1989 & 2004, Working Together to Safeguard Children 2013 and amendments March 2015.



The above framework is a useful guide for assessing needs of children and their families.

Principles of Safeguarding

Early identification of need and early intervention is essential to ensure the welfare of the child. It is paramount that agencies work together and professionals share information to ensure effective safeguarding.

If any advice is needed, the midwifery safeguarding team can be contacted via email: Plh-tr.MidwiferySafeguarding@nhs.net or telephone (4)31503 or 31504

Safeguarding and promoting the welfare of children is defined as;

- Protecting children from maltreatment
- Preventing impairment of health or development
- Ensuring that children are growing up in circumstances consistent with the provision of safe and effective care
- Taking action to enable all children to have the best outcomes.

Safeguarding pathway

Child Protection

- Refers to an activity that is undertaken to protect specific children who are suffering or who are likely to suffer significant harm (Section 47 Children's Act 1989)
- Professionals have an obligation to share information on a need to know basis in order to safeguard the welfare of the child

Child in Need

- Children defined as being 'in need' under section 17 of the Children's Act 1989, are those who's vulnerability is such that they're unlikely to reach or maintain a satisfactory level of health or development, or their health and development will be significantly impaired without the provision of services.
- Professionals should only share information with the consent of the patient

Safeguarding processes

Identification of Vulnerability

The actions of professionals to meet the needs of these children, as early as possible, can be critical for their future.

Cause to consider as vulnerable should include:

- Under 16yrs old
- Care leaver / 'looked after child'
- Single with no family support
- Homeless / no fixed abode
- Asylum seeker / illegal immigrant / refugee
- History of domestic abuse
- Antenatal diagnosis of fetal anomaly
- Sibling within the family home with a disability
- Mental health issues
- Learning difficulties
- Substance or alcohol misuse.
- Failure to engage with midwifery services, repeated admissions or persistent non-attendance of appointments
- Previous Social Care involvement with other children, as child in need or child protection.
- History of human trafficking or Slavery
- History of Child Sexual Exploitation (CSE)
- At risk or have suffered from FGM

Once identified as vulnerable, consider if a Safeguarding Children and Midwifery Alert Form **(SCMAF)** should be completed via SALUS. If your concerns are sufficient to warrant a social care referral **do not** complete a Salus form as well. The SCMAF has an automatic send facility when saved and a copy will go to the safeguarding team. If it is not possible to complete an online form via SALUS, then complete an old safeguarding alert form found in G drive and send to Plh-tr.MidwiferySafeguarding@nhs.net

All forms will be reviewed and if appropriate the woman will be allocated to a Safeguarding (SG) Link Midwife for enhanced care throughout the pregnancy and postnatal period. An e-mail confirming the review will be sent. Information should not be passed to the safeguarding link midwife until confirmation has been received that this is who will providing care for the woman. The SG link MWs do not provide intrapartum care.

A copy of either form needs to be sent to the GP and the Health Visitor (although if working in Plymouth, the SG admin team will do this). Consider making a referral to their local Children's Centre as this can offer support from outreach workers based there.

Common Assessment Framework (CAF) or Early Help Process

This can help professionals work together with the family to assess, identify needs and formulate a plan of action for the child/unborn. Consent is needed by the mother before a CAF or Early Help can be done. CAF reviews are held at regular intervals to ensure the agreed plan is effective. The CAF document and all reviews are filed in the 'unborn' SG section in mother's hospital case-notes. Copies are given to all attendees including the parents. The CAF co-ordinator is also sent a copy so it can be stored in the CAF main records.

When the family do not consent to a CAF, professionals should liaise with the SG team. A referral to Children's Social Care should be considered.

Identification of Child Protection

Consider referral to children's social care in cases of:

- Family with current/past involvement with Children's Social Care.
- either parent having a probation officer
- family history of sexual offences, violent crimes or criminal activity
- drug or alcohol misuse, domestic abuse, mental health or learning difficulties which could impact on ability to parent safely
- late pregnancy booking or concealed pregnancy
- Mother with Female Genital Mutilation
- It is suspected that the mother is a victim of human trafficking or slavery
- Surrogacy, when there is no evidence of legal documentation and appropriate assessments.

All details of telephone calls made to Children's Social Care for advice should be documented. Ideally do not make any referrals until after pregnancy viability confirmed on scan.

For concerns which meet threshold for Child Protection, a referral form should be completed. These are done electronically; forms available on the Healthnet. N.B. Plymouth has different forms to Cornwall/South Devon. Cornwall has multi-agency referral unit (MARU), Devon has multi-agency safeguarding hub (MASH).

A copy of the form should be emailed to the SG team who will forward to the SG link midwife.

Professional differences
When there is a 'difference of opinion' (concerns raised not meeting Social Care threshold) professionals should seek advice from a Child Protection Supervisor or a SG team midwife.

Historical Safeguarding
In cases no longer relevant, a chronology of any conversations held with the family, Health Visitor, colleague or Child Services clearly identifying this has been recognised as historical and that there are no longer concerns should be completed, then filed in SG section in maternal hospital case-notes.

Triage admission
Maternity reception should alert staff when the hospital notes for women admitted to triage are traced to the safeguarding shelf. The midwife should access the notes to obtain further information. In cases of CP, the social worker may need to be notified. Chronology stating details of the admission should also be recorded.

Safeguarding Supervision

The Supervisory process provides the practitioner with confidential reflective discussion opportunities to ensure the welfare, safety and protection of children and the wellbeing of the practitioner.

The Supervisor
The supervisor has knowledge of the Midwifery SG function, Trust policies, resources and constraints and holds sound professional judgement regarding risks, needs and resources of service users. The supervisor will document a record of all adhoc and formal supervisory sessions which are stored electronically on the safeguarding drive for audit and confidentiality.

The Supervisee
All professionals working with families require regular SG supervision. The supervisee should be aware of the difference between professional supervision and employment management.

The supervisee who holds a caseload should have formal supervision on a three monthly basis and is required to document in the SG hospital records that supervision has taken place, with whom and conclude with a clear plan of the agreed action.

The SG link midwives who primarily hold a caseload consisting of SG/CP cases are required to undertake formal supervision with a named CP Supervisor on a monthly basis. This should be documented in the SG chronology, clearly stating any plans/actions.

Domestic Abuse

Definition of domestic violence and abuse is**:** Any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. The abuse can encompass but is not limited to: psychological, physical, sexual, financial or emotional.

Domestic abuse is a CP issue. The child/unborn exposed to domestic abuse within the family home will be affected by this. Risks of physical harm is very apparent but the continual psychological effects of witnessing or hearing episodes of physical or verbal aggression has an damaging impact on the developing unborn and child.

Abuse often escalates during pregnancy.

Routine Enquiry

Routine enquiry requires staff to ask the woman such questions as;

- do you have any concerns for your wellbeing at home?
- do you feel safe?
- would you recognise domestic abuse?
- do you feel that you can make your own decisions?

Ideally all women should be offered at least one lone appointment to facilitate this.

For women whose first language is not English should have an official interpreter present to enable the discussion and not rely on a family member to interpret for them.

Routine enquiry is documented in the antenatal summary record not held in the patient's hand-held records. If disclosure occurs the practitioner should commence the SG pathway and complete SG chronology re the findings and actions made.

If domestic abuse is disclosed the women should be offered advice and contact numbers including the refuge should she not feel safe to return home.

Although in the majority of cases, it is the woman who is the victim; professionals should remember that on occasions the woman can be the perpetrator.

Multi-Agency Risk Assessment Conference (MARAC)
MARACs are held to discuss with professionals representing agencies high risk cases to determine safety plans and actions. Domestic Abuse Suicide/Homicide & Honour-based violence (DASH) is an assessment tool used for identifying cases for MARACs.

Record keeping
All entries must have the date and time together with signature and printed name. On occasions the Court request copies of SG chronology so it should always be written clearly.

Child Protection Report writing
These are needed for CP conferences or CP Review conference (see later). CP reports should be shared with a CP Supervisor or SG team member before submitting to the Conference Chairperson (Independent Reviewing Officer – IRO) by secure email address, ideally two working days before the conference. It should also be shared with the family prior to the conference but if this is not possible the IRO should be advised why.

Safeguarding Meetings

Documentation and minutes of meetings
A summary of meeting minutes must be completed and filed in the front of the unborn/infant SG notes. N.B. Children's Social Care sometimes takes weeks to send meeting minutes to the midwifery service

There are various types of meetings held. Below are some examples:

Strategy meeting
A multi-agency meeting when there is reasonable cause to suspect that a child is suffering or likely to suffer significant harm. A decision will be made following discussion of the evidence whether a section 47 enquiry should be initiated and a core assessment undertaken by social services. (www.online_procedures.co.uk/swcpp)

Initial Child Protection Conference (ICPC):
Designed to bring together family members and professionals working with the family to decide whether the unborn/child should be made subject to a CP plan.

Core group meeting
These follow the ICPC, first one held within 10 days of the ICPC. 'Core' professionals and the family attend. Further core group meetings are held every 4 weeks to assess progress, adherence to the CP plan and make amendments to the CP plan accordingly.

Child Protection Review Conference
Held within three months of the ICPC to review the CP plan with the IRO to decide if the CP plan should continue or end, and adjust it if needed.

Pre-birth meeting
These plan the in-patient care of mother and baby when a CP plan is in place. This should include visiting plans taking into account the safety of the baby, mother and staff.

Pre-discharge Planning
Held after the birth, prior to the baby's discharge home. Social Worker, Midwife, Health Visitor and any other professionals involved should attend.

Safeguarding sticker

This should be placed on the inside of the front cover of the hospital case-notes in the 'Alert Box'. It should also be placed inside the cover of the mother's hand-held pregnancy notes so it is not visible to others. The postnatal mother and baby (purple) notes should also have a SG sticker visible for staff seeing them in the community. The management plan should detail if a CP plan is in place and that SG chronology needs to be maintained.

Storage of safeguarding paperwork
Maternal hospital case-notes relating to SG cases are stored on the SG shelf in the maternity reception.

A 'neonatal' divider card is placed in the maternal hospital case-notes. A green SG chapter card and SG paperwork should be filed behind this. A copy of any SCMAF/Social care referrals should also be stored behind a second SG chapter card in the maternal hospital case-notes.

After the baby is born, the SG paperwork for the 'unborn baby' is removed from the maternal hospital case-notes and transferred into the live baby's hospital case-notes. A hospital number can be generated after the baby's birth so the case-notes for the baby can be traced.

Discharge to community setting

Transfer of care should be a professional to professional face to face or verbal handover of safeguarding issues.
Upon discharge from hospital the SBAR should clearly state any SG issues and that this has been handed over verbally to community staff.

With transfers to another Trust area the same is done. The discharging midwife should also liaise with the midwifery service, local GP and Health Visiting Team.

Communications

National/Internal Alerts

Info re SG/CP issues e.g. missing patients is stored in G drive: Maternity stats: Safeguarding

Interagency communications

It may not be appropriate to seek consent for information sharing if risk to the woman, unborn/child could occur. Security of information sharing must still be considered but should be proportionate to the sensitivity of the information and the circumstances. The Data Protection Act is not a barrier to sharing information but provides a framework to ensure that personal information is shared appropriately.

Surrogacy

Definition: "Surrogacy is the practice whereby one woman carries a child for another, with the intention that the child should be handed over after birth". (RCM 19997) Surrogacy is legal in the UK and is controlled by the Surrogacy Arrangement Act (1985) and the Human Fertilisation and Embryology Act (1990).

Responsibilities of the midwife

Confidentiality should be maintained wherever possible. Most surrogacy arrangements are made through an organisation such as Childless Overcome through Surrogacy, (COTS).

Matron should be made aware after booking. A plan should be formulated re delivery and early postnatal period with the surrogate mother and the commissioning mother. A SCMAF should be completed and a record of plans should be kept in the unborn SG notes.

If surrogacy arrangements become known in late pregnancy, or without an organisational arrangement, contact Children's Social Care for advice.

Legal guardianship of the baby remains with the birth mother until birth registration naming the father so he has parental responsibility (PR). Until this has occurred, the birth mother must give consent for any treatment/screening. The surrogate mother should be offered the opportunity to remain with the baby during the hospital stay.

If there are any changes to the written plan, surrogacy arrangements or medical complications of the infant or birth mother, further advice should be sought from Children's Social Care.

The infant should leave the hospital with the birth mother (or the father once PR has been confirmed).

Female Genital Mutilation

All women, particularly those who are from areas of high prevalence (primarily African) of Female Genital Mutilation (FGM), should be asked at booking using appropriate terminology such as “have you experienced ’cultural cutting’, surgery or piercings around the vaginal area” with the use of an official interpreter as required, preferably a female.

If this has occurred, a referral is made to Children’s Social Care even if the scan indicates the baby as being male. Children services are required by law to undertake an assessment to determine the risk to the child or it’s siblings as this procedure is illegal in this country. An FGM proforma also needs to be completed and sent to the general SG email: plh-tr.safeguarding@nhs.net

Persons who pose a risk to mothers, babies, the public or staff

Managing people identified ‘as presenting a risk or possible risk of harm to others in the healthcare setting’ including people with history/criminal record for violence, aggression or threat to harm should be assessed. This includes people with conviction for an offence or sexual offence against a child who are known as a risk to children.

Assessments are completed sensitively respecting the rights of the person concerned. They should be informed this process is taking place, unless to do so would place others at risk of harm. It is carried out by at least two staff members include either a member of the SG team or Matron. Assessment is often based on information received from other agencies.

Once the assessment is complete and a decision made whether the person is permitted in the maternity unit, with or without suitable supervision, the risk assessment document should be completed and filed within the maternal hospital case-notes. A letter stating the outcome should be sent to the person with explanation of the decision.

If someone excluded from the maternity unit presents here and refuses to leave or causes any concern outside the building, hospital security staff should be contacted (security office tel. 432000). If needed urgently they can be ‘fast bleeped’ via switchboard on 3333. Clearly state location and need for urgent security presence. The Police should also be contacted (tel. 999) if an arrest is likely to be needed.

Rapid Assessment of Patient on Admission’ (RAPA) marker for IPMS system

Upon receipt of a SCMAF/Children Social Care referral the SG admin staff place a flag on PIMMS. This indicates a SG concern and highlights a need for the practitioner to check the hospital case-notes for SG information.

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Vulnerable family identified

NO vulnerability identified

Review medical notes and liaise with the GP

Copy of pregnancy booking forms sent to central Health Visiting Lead (via community MW office)

Family Nurse Practitioner (FNP) Supervisor reviews them for any suitable candidates (of <22yrs) for FNP or MESCH programme

Late referrals can be referred directly to FNP Admin assistant tel 01752 434314

Midwife to consider:

- Referral to **Children Centre** Outreach workers can offer support & assistance
- Family Nurse Partnership (**FNP)** or Maternal Early Childhood Sustained Home-visiting **(MECSH)**
- **Completion of SCMAF** if identified as a vulnerable family with additional needs
- **Need for CAF assessment** (with maternal consent) For advise & CAF not already in progress CAF co-ordinator =Plymouth 01752 307160 / Devon - MASH HUB 0345 155 1071 / Cornwall 01872 322 326
- **Referral / Discussion with Social Care Services** Plymouth for advice & to log information GATEWAY tel: 01752 307160.
- For referrals tel: HUB 01752 305200: Devon Mash 08448803563: Cornwall MARU 01579342919)
- Referral **JASMIN for current/previous substance misuse** –forward copy of pregnancy booking form to Drugs Liaison Midwife
- All forms should be sent to the midwifery SG team; Plh-tr.MidwiferySafeguarding@nhs.net

For additional support and advice discuss with **Child Protection Supervisor** in your clinical area, **Safeguarding Midwifery Team** 01752 431503/4 Email: plh-tr.MidwiferySafeguarding@nhs.net or **Safeguarding Lead Nurse** 01752 439053 Plh-tr.safeguarding@nhs.net

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Useful telephone numbers

PLYMOUTH AREA	
Safeguarding Midwife	01752 431503 mob: 07780684748
Drug Liaison Midwife	01752 431504 mob: 07780684756
Midwifery email	plh-tr.MidwiferySafeguarding@nhs.net
Community Midwifery Matron	01752 431950
In-patient Midwifery Matron	01752 439699
On-Call Manager	01752 763611
Named Nurse for Safeguarding	01752 439053
Trust Safeguarding email	plh-tr.safeguarding@nhs.net
Derriford Legal Department	01752 306027
Services for Children & Young People	
Plymouth HUB	Mon-Fri 9am-5pm 01752 305200
	Out of Hours 01752 346984
Plymouth referral email address	multiagencyhub@plymouth.gcsx.gov.uk
Plymouth Email address for CP reports	childprotect@plymouth.gcsx.gov.uk
Cornwall MARU Multi-Agency-Referral- Unit	0300 123 1116
Cornwall Social Care	9am-5pm 01579 342919 Out of hours 0300 123 4101
Devon Social Care MASH Multi-Agency- Safety-Hub	0844 880 3563 mashsecure@devon.gcsx.gov.uk
South Hams (Totnes) Social Care	01803 386080
Tavistock	01392 386080
Common Assessment	
CAF co-ordinator:	01752 307160 mob: 07774336579
Plymouth City Services	
Domestic Abuse Unit Devon & Cornwall Police	08452777444
Plymouth Domestic Abuse Service (PDAS)	01752 252033
Plymouth Refuge	01752 562286
Family Nurse Partnership Lead	01752 434314
MECSH Health Visiting Team	01752 434008
CAMHS Professional Advice Line	01752 431613
South Devon Domestic Abuse Service	01364 644088
West Devon Domestic Abuse Service	01837 552288
For MARAC referrals	please liaise with Safeguarding Midwives
FAST BLEEP DERRIFORD SECURITY STAFF via switchboard 3333	

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Auditable standards:

Please refer to audit tool, location: Maternity on c|1-file02', Guidelines

Reports to:
Clinical Effectiveness Committee _ responsible for action and implementation of recommendations from audit

Frequency of Audit:
Every 2 years

Responsible Person: Safeguarding Midwife

Training Requirements:

Audit of training needs compliance – please refer to TNA policy

Training needs analysis:

Please refer to 'Training Needs Analysis' guideline together with training attendance database for all staff

Cross references : Trust Child Protection Policy

Trust Child Protection Supervision Policy
Local Safeguarding Children's Board Policies
Vulnerable adult Trust policy

Antenatal Guideline 31 - Maternity Hand Held Notes, Hospital Records and Record Keeping
Guideline No. 42 Care of women who are 'unbooked' or have moved from another area

References:

Children's Act 1989 & 2004. HM Gov. London
Working Together to Safeguard Children March 2015. HM Gov. London
Foundation for people with Learning Difficulties. Valuing People's Team. www.elfrida.com
Sharing Information. Guidance for Practitioners and Managers. April 2006. HM Gov. London
Local Safeguarding Board. www.plymouthscb.org.uk
CAF www.plymoth.go.uk/commonassessmentframework
Safeguarding Procedures www.online_procedures.co.uk/swcpp
Trust safeguarding documents
http://nww.picts.nhs.uk/PHNetlive/DesktopDefault.aspx?tabid=736

Author	Julie Reynolds and Anne Smith	
Work Address	Maternity Unit Derriford Hospital	
Version	5	
Changes	Updated April 2016 (previous version valid until Dec 2016 but changes needed)	
Date Ratified	May 2017	Valid Until Date May 2022