National Mapping of Service Provision in Scotland

SPN Safeguarding Midwives Group

Contents

This document has been prepared by NHS National Services Scotland (NSS) on behalf of the Scottish Perinatal Network (SPN). Accountable to Scottish Government, NSS works at the heart of the health service providing national strategic services to the rest of NHS Scotland and other public sector organisations to help them deliver their services more efficiently and effectively. The SPN is a collaboration of stakeholders involved in maternity and neonatal care, who are supported by an NSS Programme Team to drive improvement across the care pathway.

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Midwives' responsibility for child protection

The Nursing and Midwifery Council (NMC) Standards of Proficiency for Midwives (2019) include the responsibility of midwives to respect and promote human rights and optimise very early child development. The United Nations' Convention on the Rights of the Child (Incorporation) (Scotland) Act 2024 provides universal, inalienable, indivisible and interdependent rights to infants. In line with the Maternity Pathway and Schedule of Care 2025, midwives are responsible for applying the principles of Getting It Right For Every Child (GIRFEC), Scotland's child rights approach to wellbeing, to optimise outcomes and ensure infants realise their rights from birth.

At Board level, the Scottish Government's (SG) National Guidance for Child Protection in Scotland (2023), Child Protection Learning and Development National Framework (2024), and the NHS public protection accountability and assurance framework (2022), reinforce the need for a maternity workforce skilled in pre-birth risk assessment and early intervention, with midwives, health visitors and social workers as key professionals collectively safeguarding and protecting babies.

Safeguarding Midwives Group

The Scottish Perinatal Network (SPN) hosts a nationally representative Safeguarding Midwives group. One of its core objectives was to understand and champion the role of safeguarding in midwifery, both as a specialist role and themed through all midwifery practice. At a group meeting in 2023, members discussed challenges to midwives providing immediate antenatal care, such as delays in social work involvement in cases with child protection concerns, compounded by variation in criteria and pathways across local authorities. Also, challenges of interpreting and applying policies designed to protect children in pre-birth context, including the balance of individualised antenatal care and women's rights, and ensuring child rights are realised from birth. It was agreed that need for robust relationships and multi-agency team working increased with an increase in women with socially complex needs.

Scoping Survey

The Safeguarding Midwives Group representative from each Health Board was asked to complete a scoping survey, involving colleagues as appropriate, to understand how their Board provides care for pregnant women with social complexity. The survey was open from November 2023 to May 2024.

The responses would be collated and analysed to give an overview of what safeguarding midwifery services exist across Scotland, how they are distributed, how they are delivered and by whom. Also, to identify opportunities for colleagues in similar roles to share learning and best practice and to support each other, recognising the psychological and emotional impact of providing care to women and families with social complexities.

Responses were grouped as 'small' (annual birth rate <2000), 'medium' (>2000 – 4000) or 'large' (>4000), collated, themed, and analysed. Responses were received from 11 of 14 Health Boards in Scotland - four small, five medium, and two large Boards.

Survey Findings

It was evident that in some Boards the prevalence of social complexity in pregnancy has driven the development of specialist midwifery roles. However, there was significant national variation in whether, where, and how this specialist care was provided.

What best describes the model of care for pregnant women with social complexity in your Health Board?

Seven of the 11 Boards which responded had a specialist team providing care to women with complex social needs. Typically, these were medium and large boards (i.e. Boards with annual birth rates >2,000 or >4,000, respectively). Two small Boards had no specialist team; however, a specialist midwife provided support and advice. The other two small boards had neither a specialist team nor midwife role. Their job title was most commonly Safeguarding or Child Protection Midwife, Specialist Midwife, and in one Board Public Protection Midwife.

What do the teams look like?

Across the seven Boards with specialist safeguarding teams, there was variation in team size, whether team members were case loading midwives, and Band 6 or Band 7. However, the team leader was consistently Band 7 in each Board. Some also had access to senior specialist safeguarding knowledge from other teams within the Board.

The smallest specialist teams had two members and the largest had ten. However, team size was not linked to either the number of births per annum in the Health Board or the number of unborn babies on the Child Protection (CP) register. For example, in two similarly sized 'medium' Boards, one had 62 unborn babies on the CP register for 2022 and a team of 4. The other had 41 unborn babies on the CP register, and a team of 10. A 'large' Board with 66 unborn babies on the CP register had a team of only 3.

Two teams included a Maternity Care Assistant role, one also had administrative support.

Skills and training

The most common formal training held by specialist safeguarding midwives was postgraduate certificate (PGCert) in Child Protection, and one senior colleague had a master's degree. Others had completed MSc Health Studies (with a child protection related dissertation topic) or a postgraduate nursing course on substance misuse, family & society.

One Health Board provided level 3 Child Protection training for all midwives, which was considered essential to their role in line with Royal College of Nursing (RCN) Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff 2019. Alignment with this particular piece of guidance was mentioned in only one Board. However, the principle of consistent training requirements could be explored for scaling up to national.

Interpretation of the 'levels' of child protection training is complex, as applications, definitions and delivery methods have changed over time. However, the SG Child Protection Learning and Development National Framework (2024) has sought to bring clarity. NHS Education for Scotland (NES) offers two online modules which were commissioned by SG at 'informed' and 'skilled' levels relating directly to the national child protection guidance. The modules are designed to serve as foundation training, upon which additional local multi-agency or higher-level academic training can build.

Referrals and Caseloads

Only medium sized Boards (annual birth rates >2000 – 4000) were able to quantify their referrals for safeguarding midwifery. They received an average of 266 referrals per annum, ranging between 200 and 400. Some explained they could not provide this information because it was held by Social Services, not within the Board.

Most Health Boards, especially those with larger safeguarding teams, accepted referrals of pregnant women affected by a wide range of social complexities and vulnerabilities such as criminal justice or social work involvement, learning or other disabilities, mental health issues, or domestic violence. However, ability to accept referrals was at times restricted by factors such as capacity, geography, and prioritisation criteria.

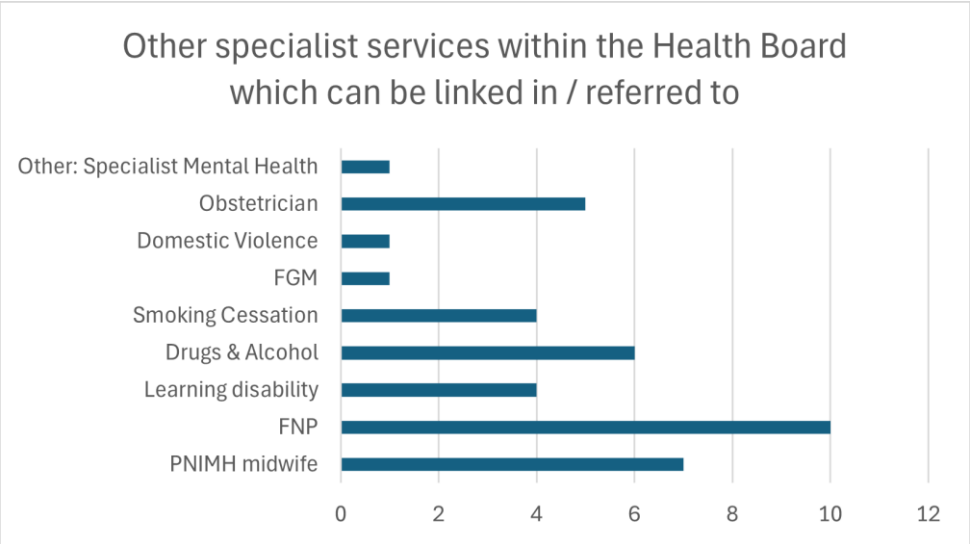
For example, the smallest teams accepted only referrals affected by substance misuse or homelessness. Others offered specialist care only to women living in certain parts of the Health Board area, resulting in geographical inequalities within and between Boards.

Nine of the 11 Boards did not routinely continue antenatal safeguarding care into intrapartum care. The other two did, by including safeguarding midwives on the labour ward rota. One of these was an island board, suggesting that smaller teams and caseloads, and a remote and rural context, are not barriers to providing continuity of safeguarding care.

Partnership working within the Health Boards

Seven Health Boards described multi-disciplinary team or partnership working which involved, for example, Health Visitors, Healthcare Support Workers, and GPs.

Respondents listed other specialist services within their Boards which could support or take referrals on particular issues, including Perinatal Mental Health (PNMH), Infant mental Health, Family Nurse Partnership (FNP), Learning Disability, Drugs and Alcohol, Smoking Cessation, Female Genital Mutilation (FGM), Domestic Violence or Safeguarding Obstetricians.

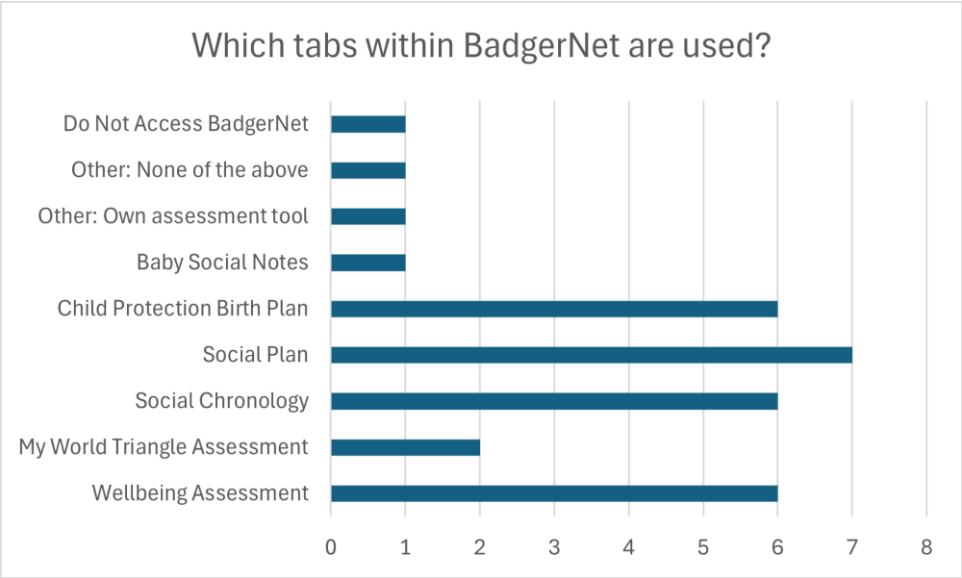


All respondents selected at least one of the options above. Five felt their safeguarding midwife role encompassed all of them. This suggests that, to varying degrees, the safeguarding midwife role interfaces with specialist services where they exist and provides the specialist care where they do not, also compensating into gaps between services.

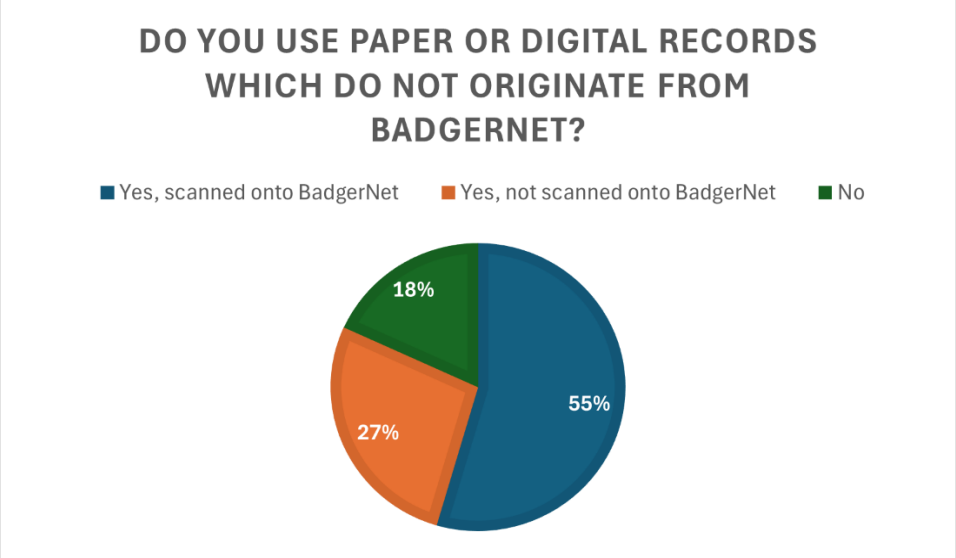
Record Keeping, Data, and Reporting

Of the 14 Health Boards in Scotland, 13 use BadgerNet Maternity as their electronic record during pregnancy. Pregnant women can access their pregnancy notes via an app, which also hosts pregnancy health information resources such as Ready Steady Baby and leaflets. Versions of these are also available in print, online and in alternative formats. Each Board has its own licensing agreement with the supplier of BadgerNet, System C, creating challenges for consistent data gathering, information governance and service benchmarking. These issues were longstanding and complex, with multiple workarounds in place to mitigate.

The survey asked which functions within BadgerNet were typically used within each Health Board, with the following options: Wellbeing Assessment, My World Triangle Assessment, Social Chronology, Social Plan, Child Protection Birth Plan, Do Not Access BadgerNet, Baby Social Notes, Other. All 11 participants responded to this question.



The survey also asked if other paperwork or records which did not originate from BadgerNet were used and, if so, whether they were uploaded to BadgerNet later.



The types of documents used which did not originate from BadgerNet included:

- Documents related to specific protocols within a safeguarding team or local Health Board context, e.g. local wellbeing assessments with resilience matrices, or chronology for unborn babies.
- Documents which originated with another agency, e.g. Local Child Protection Plans owned by Social Work
- Documents which could not be shared from BadgerNet to an MDT/interagency setting, e.g. SAM (Support and Management) notification to GP and Health Visitors.

Participants listed other software or IT systems they used to help facilitate multi-disciplinary or multiagency working. Most commonly, DCC Mosaic and CareFirst which are used by Social Work, and one who used Morse (used by Health Visitors, those working in addiction services,

and other mental health professionals). NHS Ayrshire & Arran used a multi-agency chronology called AYRshare which was based on GIRFEC, well established, and developed by the Ayrshire and Arran Data Sharing Partnership specifically to facilitate appropriate data sharing across services relating to children and young people.

When asked if they used the Child Concern Forms for unborn babies in their Health Board, seven respondents (64%) answered 'yes', and four (36%) answered 'no'.

Reportable outcome measures or KPIs

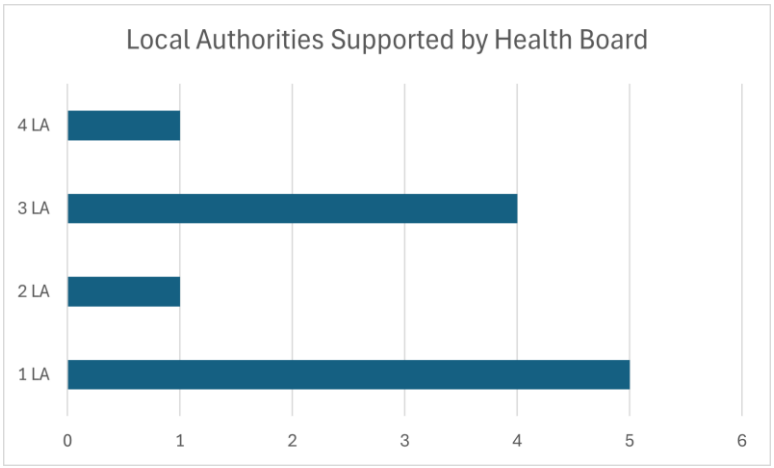
One respondent signposted ongoing local development of a minimum dataset for health. Others referred to target timescales for pre-birth processes, care assurance measures for quality, continuity standards of care, and Best Start measures.

There was inconsistency in data reporting on pre-birth child protection registration or how many women were referred to specialist teams. Six Boards provided data on child protection registration, one of which sourced the information from social work. Poor data capture on the social complexities of women using maternity services was a barrier to understanding the role of safeguarding midwifery as a specialist role and the services it could and should provide. Similarly, poor data around women's experiences of social complexities limited how complexity can be understood or inform service planning and delivery to meet their needs.

Variation in Local Authority Practice

Number of Local Authorities

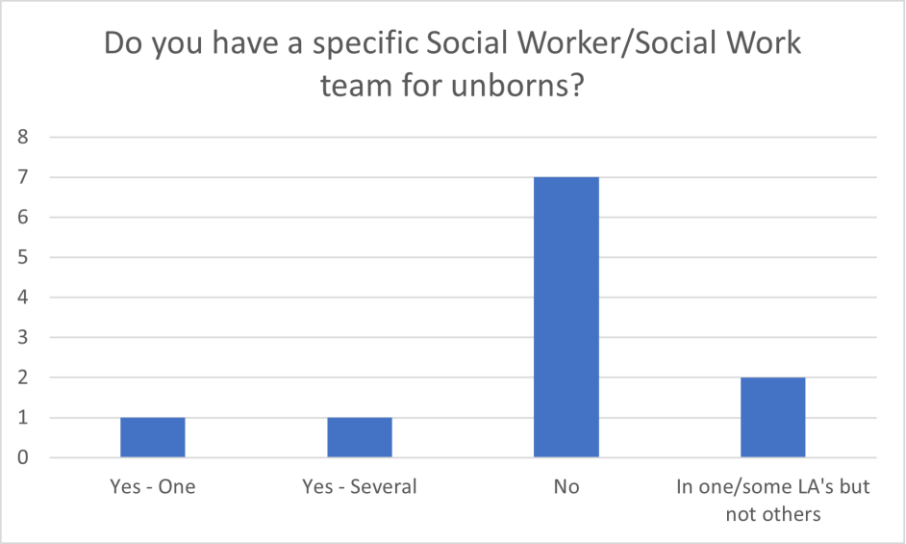
Of the 11 respondents, 5 Health Boards provided safeguarding care within a single Local Authority (LA). However, one Board provided care that spanned 2 LA's, 4 Boards provided care that spanned 3 LA's, and one Board spanned a total of 4 LA areas – visualised below.



Safeguarding is already a complex speciality with many sensitivities, and service users are people in challenging and vulnerable circumstances. Health and social care infrastructures, information sharing, governance, technologies, and processes can vary and be complex to navigate for specialist midwifery teams working with just one LA, and complexity would be compounded for those working across multiple local authorities. Potentially, more so where patients also receive care that spans Health Board and / or LA boundaries.

Specialist Social Workers for Pregnancy

One example of variation was whether LA's had a specialist Social Worker or social work team for cases which involved an unborn baby. Seven of the 11 Health Board respondents answered 'no', safeguarding midwives did not work with a person or team in social services with specific remit for pregnancy. Of the four that did, one safeguarding midwife team worked with one specialist LA team, while another worked with several specialist LA teams, each following its own processes and protocols. In two Boards, midwives had to flex between social work teams which did and did not have specialist remits for pregnancy.



Interagency Referral Discussion (IRD) Process

Another example was variation in the Interagency Referral Discussion (IRD) process. In ten of the 11 Boards healthcare workers could directly raise a referral, but in one Board it could only be raised by the Local Authority's Social Work team or the Police.

Eight Boards had access to support from a Child Protection / Public Protection advisor within their Health Board, and a colleague with this role would be involved and represent the Board in the IRD process. However in one Board, there was a specialist midwife within Public Protection, who would be part of the wider NHS Child Protection team.

Partnership Working with Other Organisations

Seven Health Boards described multi-disciplinary team or partnership working which included representation from other organisations, including health visiting, social work, criminal justice and third sector.

Prevalent Themes

Defining the Safeguarding Midwife Role

There is currently no agreed national definition of 'safeguarding midwifery' as a sub-specialty, either through a professional body, Scottish Government, or relevant NHS body such as NES.

This has led to significant variation in local interpretation of safeguarding midwifery roles, and geographical inequalities in the safeguarding care available to women between and within Boards. It has also contributed to significant expansion of safeguarding midwifery roles over time to provide any specialist safeguarding care not provided by another service.

Both safeguarding specialist midwives and those with broader safeguarding responsibilities often sought to adapt their remit to the needs of their local populations while also accommodating multi-disciplinary working in maternity services, the wider Health Board and multi-agency partners.

For example, to provide mental health care for women who do not meet criteria for specialist perinatal mental health care, or care for women affected by domestic violence where criteria for specialist safeguarding care will apply only if they also have issues with substances or after they have become homeless.

Data

Risk factors for child protection can be complex and national policies are clear there should be adequate provision of care to meet needs. The extent of imbalance between demand for safeguarding midwifery care and the ability of Health Boards to provide it is currently difficult to assess fully.

The availability and quality of data is limited around incoming and outgoing referrals, including referrals which cannot be accepted by safeguarding midwives for reasons more aligned with service capacity, geography, and prioritisation criteria than with need.

It would be useful to create mechanisms to make this data accessible to midwifery leaders so it can be analysed to inform service planning decisions. This would enable a move away from responsive 'firefighting' and towards proactive approaches tailored to reducing inequalities and meeting the needs of local populations. How to adequately support this with administrative and analytic capacity would need to be integral to these considerations.

Training

One Board provided training at a set level consistently as essential to safeguarding midwifery. This approach could be adopted nationally to upskill midwives to a consistent level across Scotland.

It could be useful to collaborate with NES to catalogue the suite of Turas resources relevant to safeguarding practice and prioritise which should be considered essential or desirable for

specialist or other midwifery roles. This could be developed into a suite of minimum standards and improve national consistency from both a service delivery and professional development perspective.

Complementary advanced learning from other training providers could be similarly prioritised as a next step.

It could be useful to consider how training could support midwives to navigate the complex national policy landscape around safeguarding, in context of their responsibilities for both the pregnant woman and the unborn child.

Conclusion

A 'Once for Scotland' approach to a specialist safeguarding midwife role could offer women with social complexities and vulnerability factors consistent quality of care, regardless of where in the country they reside. It could support:

- national equity in expectations of specialist safeguarding midwife roles.
- interfaces between safeguarding midwifery and other services, to clarify where risk of women falling through gaps between services exist; particularly where safeguarding midwife roles span multiple LA's or other specialist services.
- resolved disparity in pay for colleagues delivering equitable roles across Scotland, which could strengthen peer support relationships, equitably structured networked models, and national sharing of learning and best practice.
- improved service planning and care provision by the most appropriate service, relying less on reactive approaches and exceptional personal input by individual midwives.
- development of a national safeguarding midwife training package, with minimum standard and enhanced levels for service delivery and professional development.
- standardised KPI's and mechanisms through which to capture local and national data, understand population needs, measure impacts, and inform multi-agency decisions to support the delivery of safe, equitable, family-centred safeguarding midwifery.
- realistic recognition of workload, emotional capacity, and high-level exposure to vicarious trauma involved in providing care to women with socially complex needs.
- Informed and proactive alignment of caseload, supervision, and wellbeing support with the roles, thereby strengthening service delivery models.
- improved recruitment and retention, reduced sickness absence and burnout.

The new model would need to accommodate adequate scope for local variation and individualised practice and care. For example, team structures and approaches that work well for an island population are unlikely to be appropriate for a large city population.

For smaller boards, or where a specialist safeguarding role or team would not be practical, it could be useful to explore whether they do, or could, access specialist support and advice from another board, such as through a formal or informal buddying arrangement.

It could also explore strengths and learning from existing models which could be adapted for safeguarding midwifery, such as the Family Nurse Partnership model.