STUDY PROTOCOL

Family and professional experiences of safeguarding interventions during pregnancy: protocol for a qualitative evidence synthesis

[version 1; peer review: 1 approved, 1 approved with reservations]

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Abstract

Background

Over the past two decades, researchers have drawn attention to the numbers of babies removed from their parents at birth in England, as well as the rest of the United Kingdom, the United States of America, Canada, New Zealand and Australia. Pre-birth social work is intended to identify potential safeguarding concerns that may affect the parent(s)' ability to care for the baby safely once born, put support in place to reduce risk, and recommend a plan for after the birth. For example, for the baby to remain in the care of parents or be placed in foster care or with relatives. However, research has identified that pre-birth social work does not consistently achieve these aims, and that the process can be distressing for parents, social workers, midwives and other allied professionals. The aim of this systematic review is to present decision-makers with clear, applicable guidance to improve key stakeholders' experiences of pre-birth social work in England.

Methods

This review will adopt a qualitative evidence synthesis approach to analyse research that captures the views and experiences of parents and professionals involved in pre-birth social work in countries with a similar approach to child protection as England. The data will be analysed using framework analysis and the findings discussed with

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experts in practice and experts by experience to ensure the recommendations are relevant to the policy and practice context in England. In accordance with the guidelines, this systematic review protocol was registered with the International Prospective Register of Systematic Reviews (PROSPERO) on 20 January 2025 (registration number CRD42025639763).

Plain Language summary

Over the last 20 years, researchers have raised concerns about how often babies are taken into care at birth in England, and other countries such as the USA, Canada, New Zealand and Australia. Pre-birth social work is supposed to help parents reduce risks to their babies during pregnancy so they can care for them safely once born. However, research shows that this does not always happen, and that the process can be upsetting for parents, social workers, midwives, and other professionals.

This review will look at existing research that explores the views and experiences of parents and professionals involved in pre-birth social work in countries with child protection systems similar to England's. The findings will be carefully analysed and discussed with both professionals and people who have lived experience of pre-birth social work. The aim is to produce clear, practical recommendations that can help decision-makers improve how pre-birth social work is carried out in England and make the experience better for everyone involved.

Keywords

pre-birth social work, child protection, safeguarding, children's social care, safeguarding assessments, pre-birth, neonatal, antenatal, pregnancy, pregnant

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Contents

1. Introduction

1.1 The issue

If there are concerns about a pregnant woman's health and wellbeing, and how the parents will care for the baby following birth, she may be referred to the local authority children's services for a pre-birth assessment and support. Pre-birth social

work of this sort focuses on concerns that may arise in relation to the unborn child, including problematic substance use, poor mental health, interpersonal violence, or learning difficulties.[1] It also includes families where children have previously been removed from the parents and placed in local authority care.

Young babies are completely dependent on their caregivers and are highly vulnerable. Children under the age of one are the most likely to be killed by another person.[2] There is also increased awareness of the potential long term impact of abuse and neglect in early childhood,[3] which can influence decisions to safeguard babies.[4] The removal of children from their parents is usually seen as a last resort. Families will usually be offered support from practitioners to help them improve their situation enough for the child to remain in their care. However, ultimately a court may decide it is in the best interests of the baby to be removed from their parent(s) at or soon after birth. The baby may be placed with family members or foster carers, and this may be short term or with a view for long term custody such as a Special Guardianship Order or adoption. For the purpose of this review, removal at birth is defined as: the removal of a newborn from their parents' care within seven days of the birth due to safeguarding concerns. 'Infants' are defined as children aged over one week and under one year.

In England, a high proportion of newborns subject to care proceedings are born to mothers who have previously appeared in the family court with older children; these newborns are referred to as 'subsequent infants'. Between 2012/13 and 2016/17, 47% of newborns in care proceedings in England were subsequent infants, compared to only 7% of infants aged 39-52 weeks.[5] Evidence of unsafe parenting with previous children may influence social workers' assessments of parental capability and contribute to the court's decision to remove a newborn at birth. However, 53% of newborns involved in care proceedings were not subsequent infants.[5] In these cases, the decision that the newborn is likely to suffer significant harm is based on a prediction of future risk, informed by evidence gathered during pregnancy, rather than direct evidence of parenting.

Over the past two decades, a number of high-income countries have noted an increase in child protection involvement during pregnancy, and an increase in babies removed at birth. For example, in Australia, all jurisdictions apart from New South Wales saw an increase in the number of babies removed at birth from 2012/13 to 2018/19.[6] In 2018/19, 45% of infants placed in care were aged under 31 days and 28% were newborns, compared to 26% in 2012/13.[6] In Canada, New Zealand and Australia, researchers and civil rights groups have raised concerns that Native and Indigenous families are disproportionately affected, and that the removal of newborns from these families is indicative of colonial practices and increased surveillance of these communities.[7–9] There have been a number of attempts to understand what is happening and intervene during pregnancy to reduce rates of newborns removed at birth.[6]

It is important to note, however, that rates of newborns removed at birth is not necessarily a reflection of levels of risk. For example, a reduction in the number of children placed in care may indicate the impact of austerity measures on service functioning.[10,11] Rates of removals may also be influenced by the availability of local support service provision such as mother and baby units, the quality of legal support for parents, and trends in court processes.[12] Rates may also vary due to different thresholds for intervention in local authorities. Local authorities are responsible for developing their own threshold guidance which may vary based on support service provision, population demographics and levels of need.[13,14]

1.2 Safeguarding during pregnancy

There are international variations in how safeguarding is approached during pregnancy. For example, in Canada, as in the UK, statutory interventions cannot take place during pregnancy as foetuses are not granted personhood until birth.[9] Until 2019, child welfare authorities in Canada would instead issue a 'birth alert' if they had concerns about the safety of an unborn baby.[9] The hospital would then inform child welfare authorities of the baby's birth and a welfare professional would visit mother and baby to assess the level of risk. This practice was stopped in 2019 due to concerns that it disproportionately affected Indigenous families and was outside the legal mandate of the welfare authorities, but there are concerns it continues via alternative practices.[9] In Australia, safeguarding practices vary by state. In the Northern Territory safeguarding assessments take place once the baby is born, whereas in New South Wales, Western Australia, Queensland and Tasmania, the assessment may take place during pregnancy.[7]

In England, local authority social workers are responsible for completing pre-birth assessments and recommending where the baby should live after birth. If there is sufficient concern that a child is 'suffering or likely to suffer significant harm', care proceedings may be issued under s.31 of the Children Act 1989 to remove the child from their parents and place them in the care of the local authority.[15] While care proceedings cannot commence until a child is born,[16] children's services can begin pre-proceedings during pregnancy, during which they may decide to issue care proceedings at birth.[17] The overall aim of the pre-proceedings process is to encourage parents to seek legal advice and engage with support before care proceedings are initiated, and to make the process run more smoothly in the event such proceedings are necessary.[1] Masson and Dickens[1] found that the pre-proceedings process could support targeted work with parents during pregnancy,

but it is not known how often the pre-proceedings process is currently used. Research with parents, social workers and legal representatives has revealed that many parents are not informed that care proceedings will be issued until the baby has been born, leading to significant levels of distress and last minute court appearances, sometimes a day or two after giving birth.[16]

In addition to the increased number of newborns being removed at birth in England, such increases are taking place within a context of decreased local authority funding. Between 2011 and 2018, funding for local authorities from central government decreased by 49.1%, despite local authority responsibilities remaining the same.[18] Between 2011 and 2019, local authority spending on preventative services designed to reduce the need for children to be placed in care fell by 25%.[18] In addition to increased financial pressures, English local authorities are faced with instability in the child protection workforce, with high vacancy rates and large numbers of temporary agency staff.[19]

1.3 Geographical variations in the removal of babies at or soon after birth in the UK

In the UK, there are regional differences in the number of babies removed at birth. A sizeable proportion of children placed in care in England, Scotland, and Wales are newborns, but rates of removal vary between the nations.[20] There is a higher incidence of newborns entering care in England and Wales compared to Scotland.[5,21] Between 2013/14 and 2019/20, a greater proportion of infants placed in care were under two weeks old in England and Wales, with an upward trend over time, from 43% to 51% and 40% to 51% respectively.[5,21] In contrast, rates in Scotland remained stable over the same period, with around one-third of infants placed in care within their first week of life.[20]

Edney and Ryan[12] compared data on babies subject to care proceedings in England and Wales across two time periods. They define 'newborns' as babies aged under two weeks but note that these babies may be up to six days older, as the data relates to the week of birth rather than specific day. In England, the number of babies aged under one year in care proceedings decreased from 5,757 in 2019/20 to 5,354 in 2022/23. However, the proportion of these aged under two weeks increased from 52% to 55%. There are also regional variations within England, with London having the lowest rates of newborns in care proceedings and Yorkshire and the Humber, the North-East, and North-West the highest. In Wales, the number of babies aged under one year in care proceedings decreased from 413 in 2019/20 to 344 in 2022/23. The proportion of these aged under two weeks remained at 51%.

Not all babies subject to care proceedings are placed in care. Raab and colleagues[22] analysed data on children in the care of local authorities in England and Scotland. As the legal systems differ between the two nations, the authors used data from legal proceedings in Scotland and England, along with the Children and Family Court Advisory and Support Service (CAFCASS) data in England. The legal proceedings data defines newborns as babies aged under one week and infants as those aged under one year, whereas CAFCASS defines newborns as aged under two weeks. This data suggests that in Scotland the number of newborns aged under one week placed in care at birth decreased from 260 in 2014/15 to 180 in 2019/20, and that in England, the number of newborns aged under two weeks placed in care increased from 1,984 in 2014/15 to 2,914 in 2019/20. These numbers may be significantly higher when including babies who become looked after by the local authority without a legal order being granted.[23] Bilson and Bywaters[23] report that when babies who were removed under s.20 of the Children Act 1989 are included, 44% more babies were taken into care at birth in England between 2008 and 2017 than was found through analysis of court proceedings data alone.

1.4 Consequences of removing babies at birth

Removing babies from their parents at birth is traumatic for both parents and professionals[24] and may also have implications for the baby.

1.4.1 Consequences for parents

Concerns have been raised that the impact on parents of their baby being removed at birth further compounds their challenging circumstances, reducing the likelihood of reunification and increasing the risk of rapid, repeat pregnancies with subsequent newborns also being taken into care.[16]

The distress caused by a newborn being taken into care can contribute to increased maternal substance and alcohol use, worsened mental health, and risky behaviours such as unsafe sex, self-harm,[25] and suicide.[26] Distress can be heightened when separation is a result of urgent care proceedings that can take place within a day or two of the baby being born, often requiring mothers to appear in court the day after giving birth.[16]

The pain and loss felt by parents after a baby has been removed can be similar to the grief experienced by parents following the death of a child.[27] This grief may be complicated by feelings of shame and increased social exclusion, as

well as the withdrawal of formal support services once the baby has been placed with carers.[27–29] This grief has been termed 'disenfranchised' as it is a loss that is often accompanied by shame and stigma that prevents it being openly discussed and shared with others.[27,29] The loss is further complicated by uncertainty about the possibility of ongoing contact with the baby, and the knowledge and hope that there may be a reunion in the future.[27,29]

Finally, the younger the child is when taken into care, the more likely the parents are to be involved with care proceedings for another newborn.[30] This pattern of mothers having their babies removed and becoming pregnant soon after may place strain on the mother's body and heighten parental distress from having multiple babies removed from their care.[28,31]

1.4.2 Consequences for practitioners

Midwives and social workers have described experiencing vicarious trauma when newborns are taken into care.[16,24] This is particularly the case when parents are not aware in advance of the plan to issue care proceedings, leading to practitioners witnessing the parents' shock, panic and distress after just giving birth.[16] Practitioners can also experience high levels of professional vulnerability in pre-birth assessment and decision-making.[32] Practitioners face a delicate balance between protecting babies and supporting parents to care for them, with the additional pressure of risking a professional reputation if the 'wrong' decision is made,[33] along with trauma and regret if a child remains with their parents and dies in their care.[34]

Research with social workers in the UK has found that a risk averse approach can influence the decision to recommend removal at birth.[35,36] For example, it has been suggested that previous experience of a child being harmed in the care of their parents is a key factor for some social workers in recommending removal at birth.[35] However, social worker decision-making is not necessarily informed by direct experience alone. Baby Peter Connelly (commonly referred to as 'Baby P') died in 2007 aged seventeen months as a result of severe abuse and neglect. Subsequently, there was a significant increase in applications for care orders.[37,38] The baby Peter case influenced social worker decision-making in two ways: a desire to prevent other children being harmed, and fear of blame if a child on their caseload dies.[38]

1.4.3 Consequences for the baby

Babies removed at birth are less likely to be reunified with their parents than any other age group, with the vast majority going on to be adopted.[23] These babies are significantly more likely to be placed for adoption than any other age group.[5] Analysis of cohort data in the Permanently Progressing study identified that in Scotland, babies in care aged under six weeks are more likely to be adopted than any other age group.[39] However, the decision that a newborn will be adopted does not necessarily lead to early permanence or stability. It can take several months, or even years, for the baby to be placed with an adoptive family.[40] In England in 2024, the average time for a baby aged under one year to be adopted after being placed in care was two years and 10 months.[41] During this time, there can be several changes in placement, disrupting attachments at a crucial stage of development.[42] In 2024, a greater percentage of babies aged under 1 experienced high placement instability (3 or more placement moves) than any other age group.[43] Moreover, all care experienced children experience a form of loss in being separated from their birth families.[43] This loss is ambiguous as in many cases the family members are present for the children psychologically but physically absent. Children may have direct or indirect contact with their birth families and/or hope to be reunited with at some point. This ambiguous loss can contribute to complex beliefs and feelings around identity and family.[43]

There are possible causes of trauma and distress that are specific to newborns. Research with parents and practitioners indicates significant disparities in how parents interact with their babies in hospital when care proceedings have been initiated. Some mothers report that their babies were placed in NICU, not for medical reasons, but because there were insufficient staff to supervise contact as required by a risk assessment.[36] When court proceedings had been issued, some parents found it difficult to focus on their baby in the hours and days immediately after birth, which negatively affected bonding and the initiation of breastfeeding.[36]

More research is needed into the care that babies actually receive during the hours and days following birth when court-proceedings have been issued. It remains unclear whether they consistently receive optimal care in relation to skin-to-skin contact, being held, and being interacted with.

1.5 What is known about pre-birth social work services

1.5.1 What is known about service design

In England, local authorities are required to assess risk to an unborn child if it is believed the baby is likely to suffer 'significant harm' when born.[15] However, the mother is not legally obliged to co-operate with an assessment or intervention during her pregnancy and care-proceedings cannot be issued until the baby is born.

Furthermore, there is no national guidance relating to pre-birth assessments or interventions.[5] Local authorities are required to develop their own protocols and there is significant variation in approach.[44] The teams delivering pre-birth social work may be responsible for completing safeguarding assessments and planning for children of all ages, or specialise in pre-birth social work. Local authorities may also commission external providers to support with this work.

1.5.2 What is known about effective service delivery

Evaluations of services working with parents in the child protection system have found that to effectively support parents, services must be multidisciplinary, holistic, personalised, and focused on building positive working relationships between client and practitioner.[45–50]

Family Drug and Alcohol Courts (FDACs) for example, work closely with parents who are in care proceedings with their children due to alcohol and/or substance use. FDACs aim to offer more personalised support than is available in standard care proceedings. A specially trained judge oversees the family's case from start to finish and meets with the parents regularly. A multidisciplinary team provides the parents with support tailored to their particular circumstances. Evaluations of FDACs have found that parents find this intensive support to be valuable in helping them address their difficulties and complete treatment for addiction.[46,50] Parents who have experienced FDACs are more likely to cease their substance and alcohol use or be on an approved treatment programme than those in standard court proceedings, and more likely to retain care of their children or be reunified with them.[46–48,50]

Particularly when working with mothers who have prior experience of children being removed from their care, effective services must take account of the fact that previous experiences of social work interventions may negatively impact engagement, and practitioners need to dedicate time to building trust and rapport.[45,49] Pause is an example of a programme designed to support women who have experienced repeat removals of children from their care and are at risk of this pattern continuing. As part of the programme, the mothers agree to use a form of long-acting reversible contraception (LARC) to pause pregnancies while they work closely with practitioners to improve the difficulties that contributed to their children being removed. The mothers are allocated a key worker who provides intensive, holistic support and facilitates engagement with services to meet their practical, emotional, psychological and health-related needs. An evaluation of Pause found that the programme was effective in reducing the number of pregnancies to women receiving the support and was viewed positively by the women and Pause practitioners.[49] By the end of the programme, the participating mothers reported decreased incidents of interpersonal violence, decreased alcohol and substance use, improved well-being and mental health, and improved engagement with professional services including health, housing, mental health, and social services. Interviews with the mothers highlighted the importance of the personal, supportive relationship with their key worker in helping them engage with the programme and other services.

Evaluations of two further specialist interventions have identified improved outcomes for mothers and babies, as well as positive experiences for both mothers and practitioners.[51,52] The Startwell and the Daisy Programmes (TDP) are both informed by attachment theory and involve specially trained practitioners working closely during pregnancy with women who have experience of children being removed from their care. These practitioners support mothers in addressing their immediate needs, understanding how their own experiences of being parented may have influenced their parenting, and continue to provide support after birth, regardless of whether the baby remains in their care. Both interventions involve the practitioners working alongside local authority social workers who are responsible for completing the pre-birth assessment.[51,52]

The evaluation of Startwell found that mothers who engaged with the programme were twice as likely to have their babies removed at birth compared to those who did not receive the service. The authors suggest that this may be due to practitioners being able to develop a clearer understanding of the mothers' needs, as the support from Startwell encouraged them to attend antenatal appointments and engage with mental health and substance use services. Interviews revealed that mothers felt more able to discuss their needs with their Startwell practitioner than with other professionals, and were better able to understand why entry to care at birth might be in the baby's best interests.[52] Additionally, mothers

who received the Startwell intervention had higher rates of reunification with their babies at 12 months than mothers whose babies were taken into care at or shortly after birth but did not receive the intervention.[52]

An initial evaluation of TDP suggests that its relationship-based and trauma-informed approach was viewed positively by both mothers and TDP practitioners. However, there were challenges in aligning some of TDP's aims and priorities with the wider structures and expectations of children's services.[51] The authors conclude that while the programme shows strong potential as a source of support for mothers at risk of having their babies removed at birth, further consideration is needed regarding how best to integrate it within statutory services.[51]

A review commissioned by the Scottish Government regarding birth families' experiences of the care system and associated services[45] similarly found that mothers valued their workers being consistent, compassionate, and reliable. They benefitted from services that offered long-term, non-judgemental support. Continuity of care was also important, as frequent changes were distressing and made it harder to build a positive relationship.

1.5.3 What is known about standard service delivery?

Interviews with stakeholders in the UK, Australia and New Zealand, indicate that standard pre-birth social work does not reflect the elements of good practice outlined above. Parents and practitioners have reported that rushed pre-birth assessments often lead to urgent care proceedings being initiated immediately after birth, causing increased distress for parents, extended family members, social workers, and midwives.[16]

Existing research has also identified that the experiences of practitioners are often consistent with those of parents, with social workers and midwives also experiencing high-levels of stress and distress when babies are removed at birth.[53–55] Midwives have reported difficulties in balancing their woman-centred approach with their safeguarding responsibilities towards the baby, as well as in maintaining professionalism while sharing in the mother's emotional trauma.[54]

Research with practitioners in social work, health, and the legal profession indicates that there are tensions between different responsibilities within these roles. These tensions contribute to challenges in balancing the needs and rights of parents, legal and statutory obligations of local authorities, safeguarding duties, and recommended practice when working with vulnerable families.[1,16,25,53–56]

Social workers and midwives have expressed concerns about the lack of training they receive in pre-birth social work and in handling the removal of babies at birth.[1,53,55,56] Social workers have highlighted the specialist nature of pre-birth assessments, noting that these are often based on potential future risk, as well as - or instead of - existing evidence of parenting.[53,55]

1.6 Rationale for this review

To date, three international reviews have examined the evidence regarding pre-birth social work. These include a literature review[24] and two systematic qualitative evidence syntheses. One of these reviews focusses on health professionals' decision-making regarding pre-birth assessments,[57] one on parents' experiences of pre-birth child protection processes,[25] and one on professional and parental experiences of pre-birth assessments and the removal of babies at birth.[24] A total of 60 unique papers were included across the reviews, reporting findings from research conducted in the UK, the United States, Canada, Australia, Germany, New Zealand, and Sweden. One paper appeared in two of the reviews.

Over-arching themes identified in these reviews include difficulties in the relationship between parents and professionals[24,25]; psychological and emotional distress for both parties[24,25,57]; parents, healthcare professionals and social workers lacking clarity in procedures[24,25,57]; and inadequate information-sharing between professionals and with parents.[24,25,57]

Two of the systematic reviews referenced above are limited by their siloed approach, focusing exclusively on either the perspectives of health professionals or of parents, without integrating insights across wider stakeholder groups.[25,57] While the literature review by Mason, Robertson, and Broadhurst[24] brought together the views of both parents and professionals and identified areas of overlap, it stopped short of translating these findings into practical, actionable guidance. The current review will move beyond these limitations by actively involving policy and practice experts, as well as experts by experience, in the process of analysis and interpretation. Through this collaborative process, a co-developed framework will be created to identify key intervention points within existing policy and practice. Mapping

the review's findings onto this framework will enable the development of targeted, relevant, and implementable recommendations.

In doing so, this review will break new ground not only by synthesising diverse stakeholder perspectives, including those often marginalised in the literature, but also by bridging the gap between evidence and practice. It will offer a unique contribution to the field by positioning lived experience and practitioner insight at the heart of a translational framework designed to inform both policy reform and frontline practice.

The proposed review will therefore include data from studies exploring the experiences of a broad range of stakeholders, including parent support networks and practitioners beyond midwifery and social work, such as those working in mental health, interpersonal violence, substance use and probation services. These diverse perspectives will be triangulated to identify overlapping experiences and highlight areas of practice that may be amenable to intervention. This approach is essential for developing meaningful recommendations for policy and practice decision-makers.

A siloed approach may be more conductive to in-depth analysis of the experiences of particular groups, and an integrative approach may, as a result, lose some of this richness. However, the primary aim of this review is to identify practical recommendations that could improve the experiences of pre-birth social work for all key stakeholders. A siloed approach could result in recommendations that are highly beneficial for one group but impractical or undesirable for another, thus reducing the real-world relevance of our findings. In addition, within a context of reduced funding and an unstable workforce, recommendations that would benefit parents must consider the reality of practice 'on the ground'. To recommend practice that would be unsustainable for practitioners would not improve circumstances for parents. Finally, research with parents and practitioners has found overlap in the challenges and desired improvements identified by both groups.[36] An integrated approached is therefore supported by existing evidence and would contribute key learning to the field, as well as practical recommendations.

2. Research aims

2.1 Aim

The aim of this systematic review is to identify areas of policy and practice that could be adapted to improve the experiences of practitioners and parents involved in pre-birth social work in England.

2.2 Objectives

The objectives of this review are to:

1. Systematically identify research that explores the experiences of parents and practitioners involved in delivering pre-birth social work, and the barriers and facilitators to engaging with such services.

2. Map the findings onto a framework developed with policy and practice concerns or priorities in mind (e.g. funding, staffing levels).

3. Identify areas that could be susceptible to intervention to improve the experiences of parents and professionals.

2.3 Research questions

To meet the aims and objectives, the review will answer the following question:

What are the experiences of stakeholders with regard to pre-birth social work services, and what helps or hinders engagement and delivery?

3. Methods

3.1 Patient and public involvement

Patients and the public were not involved in the development of this study protocol.

The aim of this review is to identify changes to policy and practice that could improve how parents and practitioners experience pre-birth social work in England. It is therefore necessary that the findings of this review are relevant to policy and practice decision-makers, practitioners and parents. Mothers with experience of pre-birth social work and a Research Advisory Group consisting of experts in policy and practice will feedback on this review and the research process. Members of the advisory group include leaders and practitioners in children's social care services in England, representatives from the judiciary and third sectors, and academic experts.

3.2 Study design

This review will adopt a qualitative evidence synthesis (QES) design. Qualitative research is the most appropriate in answering the research question, given its focus on experiences and perspectives.[58,59] QES facilitates a broader understanding of a phenomenon than any single qualitative study, and is recognised as a useful method for moving beyond questions of 'what works' to synthesise the experiences and perspectives of relevant groups.[59] Evidence from primary studies will be synthesised to extend the findings of individual studies and generate new knowledge through the accumulation of available evidence.[59]

3.3 Eligibility criteria

Studies will be selected for inclusion according to the criteria outlined below. These criteria have been developed using the PICOS question framework acronym (Population, Intervention, Comparison, Outcome, Study Type).[60] This framework has been found to result in a sensitive search likely to identify relevant papers, and to identify more papers than using SPIDER as a framework.[60]

Participants

We will include studies that explore the experiences and perspectives of pregnant women who are receiving or have received pre-birth support services during pregnancy due to safeguarding concerns, their partners and close family, and practitioners responsible for delivering such services. These practitioners may include social workers, midwives, and those working in mental health, interpersonal violence, substance use and probation services.

Interventions

Studies will be included that collect data from parents and practitioners involved with services that engage with parents when there are safeguarding concerns during pregnancy. These services may or may not be defined as 'social work'.

Comparison

This is not relevant to this QES and is not usually applicable to qualitative research.[61]

Outcomes

Outcomes for the parents receiving these services will vary, and studies will be included that collect data from parents whose babies remained in their care after birth and those whose babies were removed.

Study design and type

We will include studies that use qualitative methods of data collection including, but not limited to, interviews, focus groups and ethnography. Mixed methods studies will be included if the qualitative data and findings can be extracted from the quantitative data.

3.4 Information sources

The following electronic bibliographic databases will be searched:

- ProQuest Social Science Premium Collection
- ProQuest PsycINFO
- ProQuest Dissertations and Theses
- PubMed
- ERIC
- Sociology Database
- ASSIA

- Web of Science Core Collection
- OVID Embase
- OVID Global Health
- OVID Medline
- Social Policy and Practice

Additional references will be identified through citation chasing (backwards and forwards). Grey literature will be included (for example, doctoral theses and papers published on research webpages but not peer-reviewed journals). In addition, the Research Advisory Group contributing their expertise to this doctoral fellowship will be consulted. This Group consists of experts in the field from policy, practice and research.

3.5 Search strategy

Searches will be restricted to studies published from the year 2000 to date, to increase the relevance of findings to current systems and ways of working. Searches will also be restricted to publications in the English language due to the review team's limitations in translating papers.

The search strategy will use terms identified using PICOS and Boolean operators 'AND' and 'OR'. These search terms will be refined after testing and searching of papers for key words. Relevant qualitative search filters will be used if available.

3.6 Study records

After completing the searches, citations will be imported into Covidence and duplicates removed. Covidence is a web-based software program that streamlines the production of systematic reviews and facilitates collaboration within the review team. This software will also support with keeping a record of citations identified and excluded for reporting in a Preferred Reporting Items for Systematic Reviews and Meta-analyses (PRISMA) flow diagram.[62]

3.7 Study selection

Two reviewers will separately screen titles and abstracts against the inclusion criteria to reduce the risk of bias. Disagreements will be resolved through discussion with the wider review team. Potentially relevant studies will then be screened in full against the inclusion criteria. Reasons for exclusion of papers will be recorded and reported. Results of the searches, title and abstract screening, and full text screening will be recorded and reported using the PRISMA flow diagram.[62]

3.8 Data extraction and management

Key data will be extracted using a form created for this purpose. This data will provide an overview of the included studies. Such data will include the study authors, title, date of publication, methodology, geographical location, population demographic, key service features, strengths, limitations, and recommendations. Full texts of the papers will be loaded into Nvivo for coding and synthesis. NVivo is software developed to support the analysis of qualitative data.[63]

3.9 Risk of bias/quality assessment

Critical appraisal will be conducted using the Joanna Briggs Institute (JBI) Critical Appraisal tool for use in Systematic Reviews.[64] Research has found wide variation in assessments of quality in qualitative studies even when using standardised tools,[65] and discrepancies between the quality of reporting and the usefulness of the findings.[66] The quality of papers will therefore also be discussed by the review team alongside use of the JBI tool. There is a risk that excluding less methodologically sound studies can result in the absence of rich data,[67] and unlike in a meta-analysis, less methodologically rigorous studies may not bias the results of the synthesis, and their omission can result in the absence of relevant and important descriptive data.[68] Therefore, all relevant papers will be extracted regardless of methodological quality. However, the methodological quality of the papers will be considered and discussed in the findings, discussion and recommendations sections of the systematic review.

3.10 Data synthesis

The data from the individual studies will be combined using a framework synthesis.[69] The RETREAT tool for selecting the most appropriate method of synthesis was used to guide this decision.[70] This ensures that the chosen approach is

suited to the review question, epistemology and intended audience of the review. Framework synthesis uses existing theory to construct an analytic framework that guides the synthesis of data based on what is already known.[69] The aim of this QES is to produce findings and recommendations relevant for policy and practice decision-makers in England. The framework will guide the synthesis to represent findings in a format useful for this audience. The framework will be developed with policy and practice representatives in the Research Advisory Group and experts by experience to ensure its relevance and appropriateness. The framework will also be developed iteratively as data from the primary studies is analysed, allowing it to guide but not hinder the analysis. The framework will consist of areas that could be targeted for intervention as pre-identified in the literature, such as issues relating to the social work workforce,[19] rigid timeframes for assessments and court proceedings,[16] local authority funding,[18] and staff training and development.[24]

The QUAGOL approach will be used to support the analysis of the data.[71] This process consists of two stages, involving the researchers becoming familiar with the primary studies pre-coding (stage 1), and then adopting a step-by-step approach to coding (stage 2). A key stage of this process involves developing a conceptual framework and constantly comparing the data to the framework, which is developed iteratively in order to answer the research question.[71] As a result, this approach will support the framework synthesis and ensure the process is thorough and rooted in the data. All members of the review team will discuss and feedback on identified codes and themes. Nvivo[63] will be used to support the coding of dating and recording of decision-making to ensure transparency in the review process.

When synthesizing data to inform policy and practice, it is crucial that stakeholders can assess how much confidence to place in a review's findings.[72] GRADE-CERQual will be applied to the review to assess how much confidence can be placed in the findings.[72] This approach was developed to ensure conclusions and recommendations from a review are reached by a transparent, rigorous process, and assess levels of confidence in the review's methodology, coherence, adequacy of data, and relevance.[73]

4. Dissemination plans

The Research Advisory Group and experts by experience will contribute to plans for dissemination to ensure that the findings are communicated to key stakeholders in an accessible way.

A requirement of NIHR funding is that publications must be open access. This review will be published as an open-access, peer-reviewed journal article. Other forms of dissemination may include a blog post, summary briefing, or social media post depending on feedback from the advisory groups.

Data availability

The PRISMA-P reporting checklist[74] is available at Oxford University Research Archive[75] under 'Family and professional experiences of safeguarding interventions during pregnancy: protocol for a qualitative evidence synthesis PRISMA-P checklist', DOI: https://ora.ox.ac.uk/objects/uuid:bd0acbad-923a-4027-bee6-5ecf30b9d0c7.[76] Datasets for the completed systematic review will be made available in the Oxford University Research Archive.

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Open Peer Review

Current Peer Review Status: ? ✓

Version 1

Reviewer Report 16 March 2026

https://doi.org/10.3310/nihropenres.15488.r39776

✓ **Ingrid Höjer**
University of Gothenburg, Gothenburg, Sweden

This study addresses an important and under-researched area of social work – namely removal of babies from their parents at birth.

The introduction to the study presents a thorough description of the situation in the UK, with references to relevant research. Additionally, this introduction provides a clear understanding for the need of more research to improve the situation for parents and practitioners.

The aim of the systematic review and the methods that will be used are clearly presented, and relevant for this type of study.

I have one additional comment: There is not much focus on the perspective of children. I reacted on the following sentence on p 5: *Consequences of removing babies at birth*
Removing babies from their parents at birth is traumatic for both parents and professionals24 and may also have
implications for the baby.
We know from research that removals of babies will most certainly have huge implications for children. This is also accounted for in the introduction. I am aware of that the aim of the review is to "improve the experiences of practitioners and parents involved in pre-birth social work in England" and does not include the situation for children. However, it might add to the quality of the review with and increased focus on "childrens´ perspective", where impacts of removal on babies and infants are addressed.

Is the rationale for, and objectives of, the study clearly described?

Yes

Is the study design appropriate for the research question?
Yes

Are sufficient details of the methods provided to allow replication by others?
Yes

Are the datasets clearly presented in a useable and accessible format?
Yes

Competing Interests: No competing interests were disclosed.

Reviewer Expertise: Social work with children and families, child welfare, foster care

I confirm that I have read this submission and believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard.

Reviewer Report 11 March 2026

https://doi.org/10.3310/nihropenres.15488.r39689

?

David Hayes
School of Social Sciences, Education and Social Work, Queen's university Belfast, Belfast, Northern Ireland, UK

Paul McCafferty
School of Social Sciences, Education and Social Work, Queen's University Belfast, Belfast, Northern Ireland, UK

The proposed systematic review addresses an important issue and aims to provide clear guidance to improve key stakeholders' experiences of pre-birth support in England. On a minor point, the term 'pre-birth social work' is used in earlier parts of the protocol but later the term 'pre-birth support' is used. As the review proposes to capture the views and experiences of a range of professionals, not just social workers, it might be more appropriate to use the term 'pre-birth support' consistently throughout the protocol.

The protocol is fundamentally sound. However, some minor revisions are needed to strengthen:

1. Justification for the new synthesis
2. Methodological clarity around search strategy and synthesis
3. Transparency regarding stakeholder involvement

The protocol is generally well structured, transparent, and methodologically grounded, with

appropriate use of established systematic review guidance (PRISMA, JBI, GRADE-CERQual). However, several areas require clarification and strengthening. They include:

1. Rationale for a new review would benefit from a sharper articulation. The authors note that three existing reviews already examine this topic. Currently the rationale is based on:
    1. previous reviews examining single stakeholder groups
    2. lack of translation into practice recommendations

While valid, the argument could be sharpened by clarifying:
    1. whether new empirical literature has emerged since those reviews
    2. whether previous syntheses used different methodological approaches
    3. what new analytical insights this review will generate

2. Use of PICOS for qualitative synthesis needs justification
The protocol uses PICOS to structure inclusion criteria.
While the authors cite literature suggesting PICOS can produce a sensitive search, it is normally used in quantitative syntheses. Most qualitative syntheses use:
    1. SPIDER
    2. PICo

The manuscript acknowledges SPIDER but opts for PICOS.
Given the qualitative focus, the authors should clarify:
    1. why PICOS was selected over PICo/SPIDER
    2. how the framework captures qualitative phenomena of interest

3. Framework synthesis requires clearer specification
The protocol proposes framework synthesis informed by policy and practice priorities which is appropriate.
However, the description of the framework development process is somewhat ambiguous.
Key issues needing clarification include:
    1. whether the framework will be deductive, inductive, or hybrid
    2. how stakeholder input will be integrated without introducing bias
    3. how disagreements in coding or framework development will be resolved
    4. whether coding will be conducted by multiple reviewers

Because framework synthesis involves a priori structuring of analysis, it is essential that the process is transparent and reproducible. At present, the protocol risks appearing overly flexible, which raises concerns about analytic rigour. It is not clear that, if another researcher used the protocol as is, that they would be able to reproduce it.

4. Integration of stakeholder perspectives is a strength but needs methodological clarity. The authors plan to involve practitioners, policy stakeholders, and experts by experience in interpreting findings and developing recommendations. However, the protocol should specify:
    1. how stakeholder input will be collected (workshops? interviews?)
    2. whether this constitutes a formal stage of analysis
    3. how stakeholder interpretations will be integrated with the synthesis

Otherwise the process risks appearing methodologically under-specified.

5. Quality appraisal strategy
The decision not to exclude studies based on methodological quality is acceptable in qualitative synthesis.
However, the protocol should clarify how low-quality studies will be used and weighted in analysis.

Is the rationale for, and objectives of, the study clearly described?
Partly

Is the study design appropriate for the research question?
Yes

Are sufficient details of the methods provided to allow replication by others?
Partly

Are the datasets clearly presented in a useable and accessible format?
Not applicable

Competing Interests: No competing interests were disclosed.

Reviewer Expertise: Service user experiences of the child protection and criminal justice systems, the involvement of family members in child protection and child welfare processes and methods for facilitating such involvement, the practice and experiences of professionals who operate the child protection system, and social work assessment and decision making in child welfare.

We confirm that we have read this submission and believe that we have an appropriate level of expertise to confirm that it is of an acceptable scientific standard, however we have significant reservations, as outlined above.