

# **Review of health services for Children Looked After and Safeguarding in Walsall**

## Children Looked-after and Safeguarding The role of health services in Walsall

<b>Date of review:</b>	22 <sup>nd</sup> January to 26 <sup>th</sup> January 2018
<b>Date of publication:</b>	4 <sup>th</sup> May 2018
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<b>CCGs included:</b>	NHS Walsall CCG
<b>NHS England area:</b>	Midlands and East Region
<b>CQC region:</b>	Central
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## Summary of the review

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This report records the findings of the review of health services in safeguarding and looked after children services in Walsall. It focuses on the experiences and outcomes for children within the geographical boundaries of the local authority area and reports on the performance of health providers serving the area including Clinical Commissioning Groups (CCGs) and Local Area Teams (LATs).

Where the findings relate to children and families in local authority areas other than Walsall, cross-boundary arrangements have been considered and commented on. Arrangements for the health-related needs and risks for children placed out of area are also included.

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## About the review

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The review was conducted under Section 48 of the Health and Children's Social Care Act 2008 which permits CQC to review the provision of healthcare and the exercise of functions of NHS England and Clinical Commissioning Groups.

- The review explored the effectiveness of health services for looked after children and the effectiveness of safeguarding arrangements within health for all children.
- The focus was on the experiences of looked after children and children and their families who receive safeguarding services.
- We looked at:
  - the role of healthcare providers and commissioners.
  - the role of healthcare organisations in understanding risk factors, identifying needs, communicating effectively with children and families, liaising with other agencies, assessing needs and responding to those needs and contributing to multi-agency assessments and reviews.
  - the contribution of health services in promoting and improving the health and wellbeing of looked after children including carrying out health assessments and providing appropriate services.
- We also checked whether healthcare organisations were working in accordance with their responsibilities under Section 11 of the Children Act 2004. This includes the statutory guidance, Working Together to Safeguard Children 2015.
- Where we found areas for improvement in services provided by NHS but commissioned by the local authority then we will bring these issues to the attention of the local public health team in a separate letter.

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## How we carried out the review

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We used a range of methods to gather information both during and before the visit. This included document reviews, interviews, focus groups and visits. Where possible we met and spoke with children and young people. This approach provided us with evidence that could be checked and confirmed in several ways.

We tracked a number of individual cases where there had been safeguarding concerns about children. This included some cases where children were referred to Children's Social Care and also some cases where children and families were not referred, but where they were assessed as needing early help and received it from health services. We also sampled a spread of other such cases.

Our tracking and sampling also followed the experiences of looked after children to explore the effectiveness of health services in promoting their well-being.

In total, we took into account the experiences of 80 parents, carers, children and young people.

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## Context of the review

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The population of Walsall taken at the last census in 2011 was 269,323. The majority (90.8%) of Walsall residents are registered with a GP practice that is a member of NHS Walsall Clinical Commissioning Group (CCG). There are some Walsall residents that are registered with GP's that are a part of further CCG's but these are much lower in number. The latest published information from the Child and Maternal Health Observatory (ChiMat) are those from March 2017. These figures are published by Public Health England and are used to set the context for the area.

The ChiMat data shows that children and young people under the age of 20 make up 26.0% of the population of Walsall, with 37.0% of school age children from a minority ethnic group. Generally, the data indicates that the health of children in Walsall is mixed compared with the rest of England, with 25.0% of the attributes measured being significantly better than England and 40.6% being measured as significantly worse than England; some of these are summarised below. For example, the rates of immunisations for children are higher for both the MMR and the 5-in-1 vaccinations at 97.7% (compared with the England rate of 91.9%) and 98.8% (compared with 95.2%) respectively. However, significantly more children are killed or seriously injured on the roads in Walsall at 28 per 100,000 compared to 17 per 100,000 nationally.

The proportion of children living in low income families is significantly higher, at 29.9%, than the England average at 20.1%. The number of children in care is also significantly greater than England with 95, as opposed to 60 per 10,000.

Under 18 conceptions are 50% higher than the national average with 31.5 for every 1,000 pregnancies as opposed to 20.8 for England (2015 data) which is mirrored with the rate of teenage mothers at 1.6% which is double the national rate of 0.8%. (2016/2017 data)

The infant (aged 0 to 1 year) mortality rate is greater than the England average with 6.8 per 1,000 live births compared to 3.9 per 1,000 nationally. The number of babies in Walsall with low birth weights is also significantly higher than the rest of England (4.2% compared with 2.8%) and breastfeeding initiation is lower at 66.3% in Walsall compared with 74.3% nationally. There are more children aged 4-5 years with obesity (11.3% compared with 9.3%) and this data is more pronounced for children aged 10-11 years with obesity where the rate is 25.5% compared with 19.8%.

Children's dental health is also on par with the rest of England with 25.2% of children having one or more decayed, missing or filled teeth compared to 24.8% for England. However the number of hospital admissions of children aged 0-4 with dental caries is significantly lower than in the rest of England with 56.5 as opposed to 241.4 per 100,000 children.

There are significantly fewer hospital emergency department (ED) attendances for children aged 0-4 years than England at 408, as opposed to 588 for every 1,000 attendances. This is also the case for attendances caused by injuries for children aged 0-14 (86 for every 10,000 compared with 104 nationally) and young people aged 15-24 (116 for every 10,000 compared with 134 nationally).

There are significantly more young people under 19 admitted to hospital due to asthma; this is at 262 for every 100,000 compared with 202 for England. Whereas there are significantly fewer young people admitted to hospital with mental health conditions; this is at 63 for every 100,000 compared with 86 for England.

Hospital admissions for young people under 18 with alcohol related conditions are in line with the national average (37.5 for every 100,000 compared to 36.6 for England), as are the number of young people aged 15-24 admitted due to substance misuse (96.8 per 100,000 admissions compared with 95 for England.)

The Department for Education (DfE) provide annual statistics derived from outcomes for children continuously looked-after. As of March 2016, Walsall had 490 children who had been continuously looked-after for more than 12 months (excluding those children in respite care), 95 of whom were aged four or under.

The DfE data indicates that most of Walsall's looked-after children who had been looked after for 12 months or more were up to date with their immunisations (88.8%) and had had their teeth checked by a dentist (86.7%) which is in line with national averages. However the percentage of children who had an annual health assessment was significantly lower than the rest of England (78.6% compared to 90.0%). Positively the number of children aged under five who had received an up to date development assessment was higher than the national average (94.7% compared to 83.2% for the rest of England).

The commissioning and planning of most health services for children are carried out by Walsall Public Health Metropolitan Borough Council (MBC) and Walsall CCG. Commissioning arrangements for looked-after children's health are the responsibility of Walsall CCG and designated roles, with operational looked-after children's nurses provided by Walsall Healthcare Trust.

Acute hospital services, including emergency care and maternity, are commissioned by the CCG and provided by Walsall Healthcare Trust.

Community health services for children (health visiting and school nursing) are commissioned by Walsall Public Health MBC and provided by Walsall Healthcare Trust, as are the Contraception and Sexual Health services (CASH).

Child and Adolescent Mental Health Services (CAMHS) and Adult mental health services are provided by Dudley and Walsall Mental Health Partnership NHS Trust (DWMH). Including iCAMHS, an intensive tier 3.5 CAMHS service.

Child and adult substance misuse services are commissioned by Walsall Public Health MBC and provided by Change Grow Live, known locally as The Beacon.

The last inspection of safeguarding and looked-after children's services for Walsall involving health services took place in June 2012; a joint inspection with Ofsted. At that time, the effectiveness of arrangements for safeguarding children and capacity for improvement were judged to be 'inadequate' with the contribution of health agencies to keeping children and young people safe rated as 'adequate'. In relation to children who are looked after, the overall effectiveness of services for looked after children and young people and the council and partners' capacity for improvement were deemed to be 'adequate' with looked after children being health rated as 'good'. Provider recommendations from that inspection were considered during this review.

Ofsted undertook a single agency inspection of the local authority and a review of the effectiveness of the local safeguarding children board in Walsall in June 2017. Both were judged as 'requires improvement'.

Walsall Healthcare Trust was inspected by the CQC in May and June 2017. The trust was given an overall rating of 'requires improvement'. The overall ratings for Walsall Manor hospital and urgent and emergency services were also judged as 'requires improvement' with maternity and gynaecology rated as 'inadequate'. However community health services for children, young people and families and services for children and young people were both rated as 'good'.

Dudley and Walsall Mental Health Partnership NHS Trust (DWMH) was inspected by the CQC in November 2016 and was rated as 'good' in addition to Specialist community mental health services for children and young people which were also rated as 'good'.

Walsall Local Safeguarding Children board introduced a Multi Agency Safeguarding Hub (MASH) in October 2015 with the purpose of improving the service delivered to children and families at risk in Walsall. The MASH is made up of a fully co-located team including Children's Social Care, Police, Education Welfare, Probation and Black Country Women's Aid who jointly assess referrals regarding the safeguarding of children in Walsall, share information held within their respective agencies and agree a high quality and timely response. The current arrangements do not provide fulltime integrated health representation within the MASH firewall but instead consist of daily access to a nurse from within safeguarding team provided by Walsall Healthcare Trust (WHT).

All professionals must make written referrals into MASH via a recently revised Multi Agency Referral Form (MARF) and members of the public are able to make referrals over the telephone. All referrals are screened by a Children's Social Care assessment team who allocate a colour coded red amber or green (RAG) rating depending on perceived risk which informs the appropriate response from services

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## **The report**

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This report follows the child's journey reflecting the experiences of children and young people or parents or carers to whom we spoke, or whose experiences we tracked or checked. A number of recommendations for improvement are made at the end of the report.



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## What people told us

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We spoke with a number of young people and parents or carers.

### **A Care leaver told us:**

*“It’s been really good, no complaints. The Looked After Children’s (LAC) nurses are really helpful and not just for health stuff, you can go to them for anything, The LAC nurse helped me a lot and set me up for courses at college too.”*

### **The parent of a young person accessing iCAMHS told us:**

*“They (iCAMHS) always come out when you need them and they’re really easy to talk to. My daughter wouldn’t cooperate at first, but they kept coming out, they were persistent. They’ve done remarkably well with her considering she didn’t want to see them initially. Now she really opens up to them and they’ve been with her for a lot longer than they should have been so the support has been brilliant.”*

### **A Foster carer of 14 years told us:**

*“We feel very positive about health input, we get a good standard of training, the system with the doctors works well and we have had good access to CAMHS, it always runs smoothly with everybody involved as soon as you need them.”*

### **The Manager of a children’s residential home told us:**

*“The looked after children’s (LAC) nurse has been exceptional, it’s only now I’m asked to comment that I realise how much she does for us (staff) and the young people. Many of the young people here are extremely complex and won’t engage with anyone, apart from her, she seems to be able to build relationships even with the young people who won’t talk to anyone. There’s two young people in particular who will ask only to speak to the LAC nurse, she helps them with everything, not just health things but all sorts. She has so much knowledge and if we are ever stuck with anything she is our first port of call. She sorts everything out so quickly as well so young people have confidence in her and she helps introduce them to new health people (like the Contraception and Sexual Health service) so they feel happy going there”*

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# The child's journey

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This section records children's experiences of health services in relation to safeguarding, child protection and being looked-after.

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## 1. Early help

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1.1 The recent introduction of the 'health in pregnancy' team is a good universal offer to all pregnant women in Walsall operated by the health visiting service. Expectant mothers can engage with this service at the 12 and 20 week scan points and face to face advice is available on a range of public health topics. This ensures that women are supported to achieve the best start for their babies and have good access to services should they present with additional needs.

1.2 Booking paperwork at Walsall Manor promotes good risk assessment of expectant women by midwives and captures family health history and partner's details. There is an expectation that booking is completed at home but some cases seen were completed at a GP surgery with no home visits planned. The trust told us that some women are also seen at home for their birth plan, however, we were not assured that all women booking their pregnancy benefit from a home visit during their pregnancy. The absence of a home visit restricts the midwife's ability to undertake a comprehensive risk assessment of the home environment and any extraneous factors which may present a risk to the mother or unborn.

1.3 Midwives do not routinely provide expectant mothers with enough opportunity to explore concerning relationships and worries during their pregnancy. Within midwifery there is no standard procedure to see women alone during pregnancy and in most cases seen, routine enquiry for domestic abuse had not been asked with no evidence of follow up at a later stage. It was noted that in one case where services suspected an abusive relationship, persistent efforts were made by a range of midwives to attempt to see the mother alone. However this is not consistent and therefore means that women involved in coercive relationships may not be able to disclose concerns or access support to keep them and their unborn safe.

### [Recommendation 1.1](#)

1.4 Health visitors complete meaningful and holistic antenatal contacts with expectant mothers. A variety of tools are used during the antenatal contact to promote attachment between the mother and the unborn child and the assessment is led by the expectant mother, tailored to her priorities. This ensures women are engaged with community health services at the earliest opportunity, promoting the health and well-being of the unborn baby and allowing for any concerns to be identified and addressed.

1.5 Children under five benefit from delivery of the full Healthy Child Programme helping to identify families that may require additional support. This is a key stage of development crucial to identifying any early problems with growth, behaviour and language and that may have potential longer term impact. These health visiting contacts promote early identification of needs in order to promote positive outcomes in an infant's health and wellbeing.

1.6 The school nursing service has a good offer for helping parents and children with a range of common difficulties faced in childhood. The service provides a range of evidence based interventions which take a stepped approach to supporting and building resilience in children, young people and their families. Parents are therefore able to access early help, support and practical strategies in a timely manner to better equip them in dealing with the issues their child or teenager may be presenting with.

1.7 School nurses effectively engage with children and young people through the use of 'Chat Health' text messaging service. The service is monitored by trained nurses who provide advice on a range of health issues such as emotional health, drugs and alcohol, sexual health and weight management. The nurses are also able to signpost young people to other appropriate services or offer face to face contact if necessary. Good uptake of 'Chat Health' is resulting in children and young people accessing health information and support using a medium they are highly familiar with which promotes engagement.

1.8 Children and young people benefit from positive working relationships between schools and school nurses which enhances the delivery of sex and relationship education (SRE) interventions. All pupils have access to this programme and teachers are also trained in the subject matter by the school nurses to increase their knowledge. This ensures teachers are supported and empowered in managing effective delivery of evidence based SRE programmes to children and young people.

1.9 Walsall Manor hospital has improved communication and information sharing with public health nurses following the reintroduction of paediatric liaison nurse. Health visitors and school nurses receive timely notification of children who have attended the Emergency Department (ED), sometimes via telephone in urgent situations. Services are working together to ensure pertinent information is shared efficiently with relevant professionals to meet the needs of children and young people.

1.10 Notification of ED attendances to primary care is an area that requires improvement. Basic information regarding attendance is provided to GPs in an unstructured format which does not routinely include important information about any safeguarding assessment or follow up activity. This inhibits GP's ability to ensure their records accurately include any pertinent safeguarding information as the primary record holder and that appropriate follow up action is undertaken.

### **[Recommendation 1.2](#)**

1.11 Within Walsall Manor hospital ED, the layout of the children's waiting area does not support practitioners to safeguarding children and young people, as identified in previous CQC regulatory inspections. The children's waiting area is not easily observable by nursing staff and therefore there is a risk that staff may not identify the deteriorating health of a child sufficiently promptly. We were told that the trust is developing plans to address the physical challenges presented by the current the ED department. [Recommendation 1.3](#)

1.12 Children and young people who attend the ED have their postcodes recorded diligently. This is particularly important because Walsall Manor hospital ED serves a number of local authority populations and therefore has to use a range of MASH documentation when making safeguarding referrals. The ED receptionists record the correct postcodes for presenting adults and children/young people meaning that practitioners can swiftly make referrals to the corresponding local services.

1.13 Registration systems within the ED support practitioners to consider repeat presentations of individuals with risk or vulnerability factors through a prominent 'pop up' box. When someone attends the ED the number and nature of previous attendances of both adults and children is immediately shown when the patient is registered. This useful information helps to inform the ED practitioners' thinking when undertaking risk assessment.

1.14 The arrangements to assess children and young people for any existing or emerging safeguarding concerns require strengthening. The paediatric assessment documentation in the ED does not sufficiently prompt the practitioner to explore the possibility of maltreatment as outlined in NICE guidance. The current risk assessment process is over reliant on the knowledge, skill and professional curiosity of the clinician to fully risk assess children and young people. This weak practice is compounded by our finding that it is not routine practice for medics to complete basic safeguarding questions as part of the paediatric triage documentation. The page is left blank and therefore there is a lack of clarity as to whether safeguarding concerns have been explored. [Recommendation 1.4](#)

1.15 Children and young people who attend the ED due to drug and/or alcohol misuse do not receive consistent access to The Beacon drug and alcohol service. Those admitted to the Paediatric Assessment Unit (PAU) benefit from automatic referral to The Beacon service in line with best practice, however if not seen in the PAU there is no working protocol for an automatic referral from the ED. This is a missed opportunity to intervene at the earliest opportunity to ensure that children and young people exhibiting risky substance misuse behaviour are offered appropriate support. [Recommendation 1.5](#)

1.16 Young people have good access to integrated Contraception And Sexual Health services (CASH), including chlamydia testing and emergency contraception at a wide range of locations. The Walsall Integrated Sexual Health (WISH) service is available six days a week via generic walk in, or specific young people's clinics. Dedicated young people's workers also offer outreach in a variety of settings. There is a clear website which enables young people to be informed on where and when clinics are available with the option to email in questions or request a phone contact from a CASH worker. Clinic attendance levels, particularly in schools demonstrate a high level of satisfaction with the service. This means that young people are supported with regard to their sexual health and there are no barriers to accessing services.

1.17 Young people benefit from a good range of awareness raising health promotion videos and information provided by the WISH service. In many cases sampled the young person's nurse had watched the videos alongside the young person rather than simply signposting to it. This approach aided further discussions around risky behaviour and coercive relationships which is good practice to protect vulnerable young people.

1.18 The WISH team employ a holistic approach to meeting children and young people's needs. Cases sampled highlighted appropriate referrals into services such as Child and Adolescent Mental Health Service (CAMHS) and Children's Social Care with good follow up and communication to ensure young people are being supported and kept safe.

1.19 The Positive Steps CAMHS service effectively support children and young people with low level or emerging mental health difficulties. The team currently provide schools and other agencies with training, leaflets and well-being guides. This offer is being strengthened with the development of a comprehensive interactive toolkit, containing resources and targeted interventions to support the emotional wellbeing and behaviour of children aged 0 – 19, including in depth information on relevant services within Walsall. This enables professionals to support emotional health and/or well-being needs and correctly identify mental health concerns to reduce the escalation of presenting problems.

1.20 Children and young people in Walsall who do not meet threshold for CAMHS have good access to emotional health and wellbeing services most appropriate to their needs. Paediatric panels attended by multi-agency partners are convened once a week to review referrals that have not met criteria for CAMHS. The panel ascertain how the child or young person's needs can be met and where they should be referred on to. This ensures that all children are offered support and don't become 'lost in the system'.

1.21 Not all children and young people benefit from access to drug and alcohol support at the earliest opportunity. The number of young people referred into The Beacon drug and alcohol service has decreased and the team are aware this is an area for improvement. Attempts have been made to increase referrals via engagement and promotion with other services however there are still known cohorts of young people associated with risky substance misuse who have not been referred into The Beacon. **Recommendation 6.1** *This area for development has been brought to the attention of Walsall Public Health as the commissioner of The Beacon substance misuse service.*

1.22 'Think family' principles are well embedded by adult practitioners of The Beacon drug and alcohol service and workers assess needs in the context of the whole family. Practitioners ask about children with whom the client has contact, as well as those for whom they have parental responsibility, at the point of entry into service and periodically during treatment. Children's details are documented in full in the electronic patient record system and if their partner is in treatment, records are linked with good cross pollination of information and safeguarding minutes onto both records where appropriate. This ensures practitioners are aware of children associated with each client which enables a holistic consideration of risk with appropriate safeguarding referrals made where necessary.

1.23 The details of adults who accompany children to GP appointments is not consistently recorded and requires strengthening. Cases sampled did not include full names or the relationship to the child; documenting adults as "mum" or "dad" which is insufficient. This is important not only to ascertain who has parental responsibility for a child or young person, therefore able to consent to treatment, but also to understand complex family dynamics and any potentially hidden safeguarding concerns.

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## 2. Child in need

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2.1 The monthly 'unborn network' meeting plays a key role in sighting agencies on vulnerabilities and risks to the unborn at an early stage, enabling appropriate support to be put in place. This multi-agency forum chaired by the Named Midwife for Safeguarding Children is highly valued, robust and well attended; including Children's Social Care, adult and child mental health services, The Beacon substance misuse service, health visiting service, teenage pregnancy team, the delivery suite and the neonatal ward. This useful forum enables all teams to have oversight of vulnerable cases, exchange information and ensure actions are completed.

2.2 Expectant mothers with additional needs benefit from the expansion of specialist midwifery services which work alongside mainstream community midwives, in addition to the existing teenage pregnancy service for young women. The additional capacity via the recruitment of a specialist midwife for vulnerable women has facilitated weekly clinics targeting women with substance misuse issues and more recently a perinatal mental health clinic for those with significant mental health issues which further strengthens the offer.

2.3 However, there is more to do in acknowledging the complexity of women's needs in Walsall, specifically around domestic abuse for expectant women in abusive or controlling relationships. These women currently access generic community midwifery services with no specialist targeted support available to this vulnerable cohort of women. This is particularly concerning when taking into account the low numbers of expectant women who are seen alone during the ante natal booking. [Recommendation 1.1](#)



In one tracked case we saw poor safeguarding practice from a number of health services.

Maternity and health visiting services were aware of concerns regarding the family whilst the mother was pregnant due to the 'unborn network' meeting. Records indicated that the expectant mother was the victim of honour based violence. Her husband was known to be controlling and there were a number of Emergency Department attendances following domestic abuse or self-harming behaviour. However these were not appropriately shared with relevant health professionals to help inform ongoing risk assessment or care planning.

There was no evidence of the mother being seen alone by midwives or offered opportunity to discuss any concerns regarding her relationship which may have enabled earlier disclosure or intervention. When concerns were identified the referral made to MASH was of poor quality, did not fully articulate risk and there was no evidence of appropriate challenge or escalation to Children's Social Care. The absence of chronologies within maternity and health visiting services meant that each presenting concern was not fully assessed as it was considered in isolation. Supervision was ineffective in improving safeguarding practice as discussions were task orientated with no evidence of follow up to ensure actions were completed.

We asked the local area to take action on this case to ensure that this vulnerable mother and her baby were safeguarded effectively. [Recommendation 1.6](#) *This area for development has also been brought to the attention of Walsall Public Health as the commissioner of the health visiting service.*

2.4 Midwives in Walsall take a proactive approach to engaging pregnant women within the service. Within midwifery there is a robust "did not attend" policy in place and there was evidence of persistence on the part of midwives to ensure women had been seen for all appointments. Expectant women who failed to attend three appointments were referred to Children's Social Care to ensure that risks were considered from a multi-agency perspective.

2.5 Maternity services ensure women with mental health needs experience good antenatal care whilst placed in an acute mental health setting. Midwives from Walsall Manor and New Cross Hospital in Wolverhampton undertake antenatal appointments in Dorothy Patterson Hospital in-patient mental health unit. This in-patient unit operates a flexible and facilitative approach to ensure unborn are safeguarded and pregnant women have their needs met.

2.6 Not all vulnerable families benefit from GP led multi-agency meetings which underpin awareness of emerging needs and risks within families. These are in place in some, but not all, practices despite a linked health visiting practitioner to each GP practice promoting good liaison. Where operational these meetings provide effective arrangements to manage and follow-up children who are vulnerable. The absence of these meetings is a missed opportunity to ensure that safeguarding or vulnerability concerns are shared between services and with the GP as the primary record holder for health. [Recommendation 2.1](#)



2.7 Public health nurses effectively assess and meet the health needs of children within the asylum seeking and traveller population in Walsall. The specialist health visiting service for 'asylum seekers, refugees, migrants, travellers and no recourse to public funds' supports pregnant women and families with children aged up to five. There is a good offer of outreach contact, personalised health assessments, promotion of engagement with health and education services and a robust system to ensure the availability of interpreting services. There is also alignment with the school nursing service providing vulnerable children aged over five with tailored support to ensure any health needs are identified and met. This means that some of the most vulnerable children and families are supported to achieve positive integration into the Walsall community.

In one case we saw the effective work undertaken by the Walsall's Specialist Health Visiting service alongside midwifery in supporting a pregnant young woman who had been trafficked and coerced into exploitation sex work in the UK. She had been subjected to female genital mutilation (FGM) in her home country and forced to flee the perpetrators, who continued to threaten her and her family members at home. As a victim of trafficking she was supported by the police and Victim Support and placed at a 'safe house' provided by the Home Office, but had to be relocated during her pregnancy creating instability.

Decisive action was taken to ensure the unborn baby was monitored under child protection arrangements due to the pressure the expectant mother's family were placing on her to have FGM undertaken in this country. The mother had no family and little support in the UK.

After the baby was born the health visiting service made a referral to Sure Start and also the Breast Feeding Team to ensure that mother and baby had good access to appropriate support. The family stayed on a child protection plan for less than a year before it was deemed that the risks to the baby had ceased and the case no longer required statutory intervention. The mother and baby were able to transition to accessing universal health visiting services as the baby continued to thrive.

The mother was given leave to remain and secured a property locally. Her traffickers were arrested and taken to court. The mother now attends college and attends Stay and Play sessions with her daughter at a local Sure Start Children's Centre.

2.8 Children who act as carers for members of their family are supported well by the school nursing service. In Walsall, school nurses are actively involved with the local authority's Young Carers strategy and promote the involvement of a school nurse young carer's champion. Young carers receive good advice to support them in ensuring their health needs are being met and can be signposted to other agencies if required.

2.9 The school nursing service is proactive in making contact with children who are home educated to make sure their needs are fully assessed. All children are offered a health assessment and further attempts are made to engage if contact is declined. Should there be any concerns due to non-engagement or during the assessment then a referral will be made to the MASH. This helps to ensure that children who are less visible are appropriately seen to verify that they have no unmet health needs.

2.10 Public health nurses capture and record the voice of the child and the child's lived experience well, which provides a good sense of the child as an individual. This was evident in case notes, safeguarding reports and referrals to Children's Social Care made by public health nurses. This helps to convey the child's feelings enabling intervention to be child focussed rather than parent led and supports better understanding of the child's lived experience and needs.

2.11 There is a risk that young people aged 17 years old who follow the adult ED pathway may not benefit from appropriate child centred, paediatric documentation. Staff at the ED front desk have to manually select the correct child or adult paperwork, which is very similar in appearance with little distinguishing features, and this presents a risk when practitioners are operating within a busy ED environment. We saw one case example where a 17 year old had been assigned adult documentation which meant that clinicians may not have been immediately aware that they were treating a child and this young person may not have had all safeguarding concerns considered as a result. [Recommendation 1.4](#)

2.12 Practitioners within the ED are not using supplementary risk assessment tools to support identification of safeguarding concerns, such as a Child Sexual Exploitation (CSE) risk assessment when risk is identified. Despite the availability of a CSE assessment tool based on 'Spotting the signs', accessed through the trust website, this is not in use in the ED. This means there is an absence of a structured assessment to underpin the overall judgement as to whether a practitioner has identified a concern regarding a child or young person. [Recommendation 1.7](#)

2.13 Young people admitted to the PAU or paediatric ward experiencing mental health crisis are supported well through a close partnership between WHT ward staff and the tier 3.5 iCAMHS team. The iCAMHS service has extended operating times and responds promptly to requests for mental health assessment for these high risk children and young people. iCAMHS provide intensive ongoing care and support earlier discharge through safe transition back into the community. This marks a significant increase in access to mental health expertise and is leading to shorter stays in paediatrics, ensuring that high risk children and young people receive care and support in the most appropriate setting.

In one tracked case we saw effective intervention by the CAMHS service in holistically supporting a young girl and her mother whilst working through difficulties and suspected abuse in the child's upbringing. The initial referral was triggered due to aggressive behaviour at home and school alongside reports that the child wanted to kill herself.

Intensive work was undertaken by the psychotherapists alongside other social care and education professionals which enabled the child to remain in school and manage her behaviour. The team built trusting relationships with both mother and daughter and provided a safe space for discussion about difficult past experiences which led to a disclosure by the child. Specialist support has been arranged so the child can benefit from specific trauma focussed sessions to support her with the abuse that she experienced and help her move forward with her life.

2.14 Children and young people in Walsall benefit from quick access to mental health assessment and ongoing treatment. Targeted work has been undertaken to sustainably reduce the waiting time into service and currently there is no wait to access triage or treatment. Leaders have reviewed working practices and are effective in utilising administrative support and tight caseload management to ensure positive access into service is maintained so that children and young people receive appropriate high quality care. This means that there is no delay for children and young people in accessing support regarding mental health concerns

2.15 Within CAMHS there is inconsistent practice for children and young people to receive timely reviews of their progress in treatment or presenting risk factors. Records seen highlighted that risk assessments and outcome measures were not completed within appropriate timeframes. Currently, there is no flagging system to highlight out of date assessments which restricts both practitioner and management oversight of children with risky behaviours. This means that clinicians may not be considering all aspects of risk when planning interventions and may not be measuring the progress of a child or young person receiving treatment.

**[Recommendation 3.1](#)**

2.16 In adult mental health services close liaison and co-operative working between frontline practitioners and other professionals is well established. This was evident in cases seen with involvement of health visitors, social workers, The Beacon service and midwives at Walsall Manor and New Cross Hospital in Wolverhampton. Mental health contingency plans and relapse indicators, which include consideration of parenting capacity and children's needs, are routinely shared with these professionals to ensure agencies are working together effectively to prevent relapse. This arrangement could be strengthened if more detail were included about how parental relapse impacts on the child and how this is manifested in child's appearance or demeanour.

2.17 Practitioners at Dudley and Walsall Mental Health Trust (DWMH) adult mental health in-patient unit at Dorothy Patterson Hospital understand the value of maintaining relationships between parents and their children whilst in treatment. The unit has good facilities and operates an inclusive approach to supporting good contact between parents who are in-patients and their children. This helps to reduce the impact of separation between children and their parents who require specialist in-patient intervention.

2.18 Young people engaged with the WISH team receive a holistic approach to meeting their needs. The team have good links across health teams including the termination of pregnancy service and external providers for young people such as 'street teams', a charity for runaways and young people at risk of sexual exploitation. The WISH service also hold fortnightly clinics at The Beacon substance misuse service. They are proactive in sharing information and liaising across the partnership. Cases sampled highlighted good follow up and communication over vulnerable individuals to help keep them safe to ensure they have their needs met on an ongoing basis.

We heard about one case within The Beacon service where a comprehensive package of support was provided to a vulnerable 17 year old with problematic drug and alcohol use linked to exploitative situations, which included high risk injecting incidents.

To help keep this young person safe she was discussed at a number of multi-agency risk panels which operated alongside her child protection plan. The Beacon promoted effective multi-agency work with 'Street Teams' and the police CSE Team with regular information sharing, risk assessment and holistic care planning to safeguard this young person, beyond her 18<sup>th</sup> birthday.

Initially her engagement was sporadic due to her chaotic lifestyle however The Beacon continued to persist due to the ongoing concerns regarding high risk, exploitative situations where drugs and alcohol were used to increase her complicity.

Through intensive collaborative partnership working, utilising specialism in CSE, substance misuse harm reduction and education, the young person has managed to break free from the entrenched grooming and exploitation she was involved in. She has made positive changes to her life and significantly reduced her drug and alcohol use.

2.19 Adults accessing The Beacon substance misuse service, who may be pregnant or involved in safeguarding proceedings, benefit from a good service through the development of a specific Family worker and Pregnancy worker. These dedicated roles have improved the quality and consistency of safeguarding practice giving support to their client group and also expertise to the wider team.

2.20 The Beacon drug and alcohol service have robust processes in place to reduce the risk of children being exposed to potentially lethal opiate substitute medication. If there is a child under five years of age in the household, all medication is taken under supervised consumption when dispensed. If there are children aged over five in the home, the client is issued with a safe storage box and a home visit is carried out to evidence that it is being used appropriately. These measures help ensure children do not come into contact with dangerous medications.

2.21 Young people released from custody who are known to misuse drugs and/or alcohol require a more proactive approach to ensure that support is offered at the earliest opportunity. Evidence was seen of a young person with problematic substance misuse who was not supported to engage with The Beacon for a number of weeks following release from custody during a particularly high risk time. This was a missed opportunity to work in partnership with youth justice services during the pre-release planning stages to provide timely intervention to reduce reengagement with substance misuse and/or offending behaviour. **Recommendation 6.1** *This area for development has been brought to the attention of Walsall Public Health as the commissioner of The Beacon substance misuse service.*

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## 3. Child protection

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3.1 Within midwifery, safeguarding concerns are correctly identified in a timely manner but referrals made to MASH are of variable quality. In records seen there was an inconsistent standard and some referrals did not articulate risk clearly, which is compounded by the absence of an effective, operational quality assurance process. As a result, some referrals may not appear to meet threshold for statutory intervention due to the poor quality of information contained within the referral. This means that some women in vulnerable situations may not receive the appropriate level of support or safeguarding intervention. [Recommendation 4.1](#)

3.2 Midwives are fully engaged with the formal child protection and Multi-Agency Risk Assessment Conference (MARAC) processes. Records seen demonstrated consistent attendance at initial child protection conferences and core groups. This means that risks to unborn babies are managed in a multiagency forum and pregnant women receive the best support to safeguarding their child.

In one case we saw collaborative and responsive multiagency working from a range of Walsall and a neighbouring authority services. This ensured the safe birth and future planning of an unborn baby whose parents were both involved in chaotic drug use and were under the care of mental health services.

When it was identified that the expectant mother presented a risk to her unborn baby effective joined up work was undertaken and the unborn was made subject to a child protection plan under Walsall children's social care. Given the presenting risk factors a multi-agency plan was established to take the baby into care at birth and specialist foster carers were identified.

When the woman became mentally unwell and required in-patient treatment, antenatal appointments were conducted by the neighbouring authorities' specialist mental health midwife on the psychiatric unit. A plan was put into place with appropriate contingency planning for if the baby was born early which was likely due to the woman's persistent drug use. Core groups and child protection conferences were also held on the ward with strong engagement from all relevant agencies including midwives from Walsall.

At birth the baby was immediately placed under the care of Walsall children's social care. The new born was found to be perfectly healthy having suffered no apparent detriment from the mother's drugs use. The foster carers were able to visit the baby in hospital prior to discharge and the baby remains with them while arrangements are being progressed for adoption. The baby continues to thrive.

All agencies worked in a commendable, highly integrated, and co-operative way to protect this child in what was an extremely complex high risk case involving police and multiple health and social care professionals across several council areas.



3.3 The WHT maternity service uses robust alert systems to highlight safeguarding information. Electronic records reviewed were easy to navigate and safeguarding information was highly visible. This means that pertinent safeguarding information is readily available to inform care planning and risk assessment.

3.4 Safeguarding referrals made by public health nurses were appropriate and articulate the risk to the child. Records seen demonstrated that escalation processes were used to raise concerns to both Children's Social Care and also the WHT safeguarding team. This means that risks are being highlighted to the relevant services and practitioners are ensuring that the right level of response is being elicited to safeguard to children and young people.

3.5 Public health nurses prioritise safeguarding and are actively involved in child protection proceedings, including MARAC. Practitioners are committed to attending child protection conferences, core groups and child in need meetings and provide written reports with updates for each meeting. Reports submitted by health visitors to inform the decision making process gave good detail of involvement; often including lengthy chronologies based on available health history with a clear outline of risk factors. School nurses provide intervention where there is an identified health need which they are able to support with. Ongoing involvement ensures that children and young people have good access to health services to meet their needs.

3.6 Referrals into the MASH made by ED practitioners were of variable quality. One referral seen was of a good standard setting out the observations in relation to parental behaviour towards the child and articulating the risk of harm and immediacy of risk well, the other was satisfactory, stating clearly that the practitioner considered the child to be at immediate risk of harm but did not include the voice of child and made no record of child's presentation or demeanour. These additional details would have supported the assessed level of concern and aided multiagency decision making with regard to thresholds. [Recommendation 4.1](#)

In one case examined we saw a young baby was admitted to Walsall Manor Hospital paediatric ward with continual vomiting following attendance at the Emergency Department. The medical problem was quickly resolved and the baby discharged home. However, the baby returned with four further admissions for the same issue. Nurses identified that there were no feeding problems when the baby was fed by nursing staff but that the mother appeared to be struggling with caring for the infant. It was established that the baby's mother had a history of domestic abuse towards her previous partner. A safeguarding referral was submitted to MASH resulting in a Child in Need plan being put in place.

This effective identification helped to ensure that baby was safeguarded appropriately and promoted positive outcomes for the baby's health and wellbeing

3.7 The mental health crisis pathway (Section 136 Mental Health Act 1983) does not work well in Walsall. The WHT divisional director of nursing reported that the pathway is not clear or established as police partners too frequently bring young people in custody under section 136 into the ED as opposed to a dedicated health based place of safety. This means that young people held under section 136 may not be having their needs met promptly in a safe and appropriate environment.

**Recommendation 2.2**

3.8 'Think family' is well embedded within the WISH service. One case sampled highlighted the identification of a mother whose lifestyle and living arrangements may have been putting a child at risk. A safeguarding referral was appropriately completed and submitted to MASH. As a result consideration was given to the impact this mother's risky lifestyle was presenting to her child and services were offered to promote safeguarding arrangements.

3.9 The WISH team are well linked in to CSE forums such as Multi-Agency Sexual Exploitation (MASE) and CSE and Missing Operation Group (CMOG) for children who are missing and/or at risk of sexual exploitation to ensure young people are safeguarded appropriately. Records are flagged to highlight vulnerabilities to all staff and new records are created for any young person who is discussed at the meeting but not known to the WISH service. Consequently if these potentially risky young people attend a drop in clinic, all staff are aware of their additional vulnerabilities and can respond accordingly.

3.10 The WISH service prioritise young people with additional vulnerabilities such as those who are looked after or known to 'Street Teams', who support young people at risk of CSE. These young people are offered an appointment on the same day. Young or vulnerable teenagers undergo a comprehensive assessment, with thorough questioning and analysis of risks around CSE and coercive relationships, allowing for onward referrals if appropriate. This means that high risk young people have the best opportunity to engage with services and for appropriate support mechanisms to be put in place at the earliest opportunity.

3.11 CAMHS is responsive to the varying range of emotional and mental health needs of children and young people as evidenced by the services highlighted throughout this report. Plans are in place for the development of specialist service dedicated to support the emotional and mental health needs of children who have been sexually exploited. This has been prioritised in terms of commissioning intentions and will meet the needs of some of the most high risk and vulnerable children in Walsall.

3.12 Safeguarding practice in CAMHS is generally effective. Clinicians readily identify children and young people with risky behaviour or safeguarding concerns and referrals we looked at were generally of good quality and this is monitored by service leads. Practitioners prioritise safeguarding work, attendance at child protection meetings and regularly make appropriate safeguarding referrals to MASH. This means that children and young people with additional vulnerabilities are safeguarded effectively by the CAMHS service.



3.13 CAMHS, adult mental health services and The Beacon service are diligent in responding to requests for information from MASH in a timely manner. When contacted by the MASH, or WHT MASH representative, regarding Section 47 enquiries, responses are actioned within the hour and amber requests for more information within 4 hours. This means that the MASH are provided with relevant mental health and substance misuse information to inform safeguarding decisions.

3.14 DWMH adult mental health service is embedding a 'Think Family' operational service model. Adult mental health practitioners have a good understanding of their roles and responsibilities towards safeguarding children while working with adults who have mental health issues. We saw case evidence that adult mental health practitioners make appropriate and prompt referrals to the MASH when they have concerns about the safety and wellbeing of a child in the household or family.

3.15 Adult mental health practitioners prioritise and participate in child protection proceedings and attendance at relevant meetings is good. Where the care co-ordinator for the adult is unable to attend, appropriate cover arrangements are made which ensures information is shared appropriately. Child protection conference minutes and child protection plans are scanned onto the client case record system in accordance with best practice. This means that the client record is comprehensive and helps to inform mental health workers in their day to day practice.

3.16 There is a fragmented system of transmitting child protection information between The Beacon service and Children's Social Care. The Beacon do not have secure email to Children's Social Care and as The Beacon are not present in the Walsall MASH there are delays in the exchange of information. At times this has led to late invitations to key child protection meetings which has meant that The Beacon have not been able to attend as the meeting has already taken place. This reduces the efficiency of information sharing and prevents The Beacon from being involved with child protection processes at the earliest opportunity. *This area for development has been brought to the attention of Walsall Public Health as the commissioner of The Beacon substance misuse service.*

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## 4. Looked after children

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4.1 There is a real passion from the looked after children's team to meet the needs of their children, however, at the time of the review capacity was a significant issue. Health assessments for children in care, both initial and review, are currently completed in a timely fashion, however at the time of inspection school nurses were no longer able to support with the completion of review health assessments. As a result the looked after children's nurse is now undertaking all review health assessments for school aged children, meaning working overtime for lengthy periods to meet the demand. This was anticipated by service leads as likely to cause delays over the next quarter given the existing capacity issues despite a newly employed named nurse who is carrying out an operational role to support the capacity in the team. It is generally acknowledged by practitioners and managers that this is not sustainable and may lead to further difficulties if staff sickness rates increase which will further compound the capacity problems currently experienced. [Recommendation 1.8](#) and [Recommendation 5.1](#)

4.2 The recent change in review health assessment arrangements as detailed above is negatively impacting the availability and choices of location for children and young people. The impact of the looked after children's nurse undertaking review health assessments of all school aged children has decreased the availability for assessments to be undertaken in potentially more appropriate venues, such as a child's home. These factors create additional barriers to assessing and meeting the needs of children and young people who are looked after.

4.3 Initial health assessments sampled were of good quality and undertaken by appropriate clinicians with inclusion of information from health visitors and some GPs. We saw one example of excellent contribution from primary care however this was not consistent in other records sampled. The looked after children's team have delivered training to primary care to support information sharing, promote the looked after children's health agenda, holistic planning and management of needs, however GP contribution remains variable. As a result not all children and young people benefit from comprehensive information from primary care included within their health assessment. [Recommendation 2.3](#)

4.4 Strengths and Difficulties Questionnaires (SDQ) are not always available to inform health assessments despite being a key health assessment tool to enable practitioners to better understand emotional health and wellbeing needs to tailor interventions. In records sampled SDQ were completed however not in line with the review health assessment timeframes as they were received after the young person's health assessment had been completed. Consequently this leads to risk that young people's needs are not fully being met and that deterioration in emotional wellbeing will not be picked up in a timely manner. [Recommendation 1.9](#)

4.5 Capturing the voice of the child in review health assessments completed by public health nurses is underdeveloped. Whilst most assessments had a good sense of the child via comprehensive observations and/or reports from carers, there is more to do to ensure the voice of the child is recorded in children aged between five and ten years.

4.6 Health plans following both initial and review health assessments were specific, measurable, achievable relevant and time-bound (SMART), including outcome measures with evidence of follow up of child's needs. This means that children who are looked after have meaningful plans with achievable targets that are designed to improve their outcomes and reduce health inequalities.

4.7 Quality assurance processes in place for both initial and review health assessments have not sufficiently supported consistent good quality assessments. The named nurse quality assures all initial health assessments undertaken by paediatricians and a self-evaluation tool is in use to support health practitioners to complete review health assessments prior to quality assurance. Oversight is monitored via a database to record outcomes and actions taken however cases sampled highlighted ongoing variability, particularly in the quality of review health assessments. This process does not adequately promote continuous practice improvement. [Recommendation 1.8](#)

4.8 Valuable health promotion work and support for looked after children to access specialist health services has been limited due to capacity issues. The looked after children's health team are currently unable to provide these services and are now signposting into mainstream services, despite the high risk that many of these young people will not engage with generic services. Whilst the team are working hard to maintain their LAC role and previous service models, there is a risk to this service and the positive relationships that the LAC nurses have previously built up with some very vulnerable young people who may not have their health needs met fully.

4.9 Children who are looked after benefit from a dedicated CAMHS service to support their specific needs following previous relationship difficulties and environmental factors. The Fostered, Looked After, Adoption Supporting Hub (FLASH) team supports children and young people whilst they are in care or adopted around any emotional or mental health difficulties. Their flexible approach to promote engagement helps to maintain stable placements for children and prevent the risk of breakdown.

4.10 CAMHS are also part of a bespoke initiative which promotes placement stability for children in residential care. A small specialist team of psychotherapists work with both the children and staff within a specific children's home to prevent placement breakdown and ensure children are supported regarding their emotional wellbeing. The team also attend the external placement panel to influence decisions and planning of children who require residential placement with consideration of the dynamics in each children's home. This ensures that therapy for children in care is not disturbed by the introduction of other children into the setting which may have a negative or unsettling impact.

4.11 A comprehensive picture of looked after children's ongoing health activity is supported by notification of ED attendances which is logged on records. This ensures that the looked after children's health team are able to build a thorough record of any health concerns during a child or young person's time in care. This then feeds into the child or young person's health passport enabling them to have a good level of detail of their health history.

4.12 The looked after children's health team have given consideration to the specific needs of cohorts of children within their care. Children and young people with additional learning needs benefit from adapted service delivery, strategies, visual resources such as a Makaton health passport which has a positive impact on facilitating engagement and maximising outcomes for vulnerable young people.

4.13 Opportunities to develop services with the help of young people and client participation are readily used in the looked after children's health team. Young people are actively involved in service development or service user involvement work via New Beginnings Children in Care group. An example of their work is in the redesign of the health passport for care leavers.

4.14 Care leavers are being provided with age appropriate summary health information in the form of health passports as they leave care. Open access arrangements are in place for young people who do not wish to attend appointments at the point of leaving care. Work to develop comprehensive health passports has been stilted due to long term sickness of the transition and care leaver nurse, which is another example of how capacity issues are directly impacting on young people.

4.15 Adult mental health practitioners routinely attend statutory looked after children's reviews where they are working with the birth parent. Minutes from the review are included in the adult mental health client's record as a scanned document. This is good practice to ensure that practitioners are aware of children attached to adult service users and maintains involvement in risk assessment and care planning.

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## 5. Management

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This section records our findings about how well led the health services are in relation to safeguarding and looked after children.

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### 5.1 Leadership and management

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5.1.1 Walsall CCG has faced a number of challenges in improving services rated as 'Requires improvement'. It is clear that numerous efforts have been made to address shortfalls and improve services and it is positive that the revised safeguarding assurance strategy for children and adults correctly identifies MASH and looked after children as the top priorities. However, despite a number of changes within senior leadership over the last year, the pace of change has not been swift enough and the impact has been highlighted in WHT services inspected as part of this review. A rapid refresh and review of safeguarding within the trust is currently being undertaken to fully assess the situation however this was not available at the time of this report but should be completed and acted upon as a matter of urgency.

**[Recommendation 1.10](#)**

5.1.2 The current arrangements for Walsall health services' contribution to MASH processes are significantly under resourced and do not ensure all health services are consistently involved in multi-agency decision making processes. Responses to safeguarding referrals are made by a co-located, multi-disciplinary team, however health services are not always available to participate in child protection strategy discussions in the MASH, only attending at times when a WHT safeguarding nurse is situated in the building. Furthermore as some safeguarding nurses are not fully co-located within the MASH firewall, and therefore do not have access to the MASH electronic systems, this creates additional barriers to appropriately resourcing the MASH from a health perspective. Although there have been encouraging developments by DWMH who utilise teleconferencing to participate in MARAC discussions where they are not able to attend, this has not been explored to ensure mental health services participate in appropriate discussions and facilitate good decision making in the MASH in line with best practice. As a result the quality and timeliness of health services' contribution to multi-agency safeguarding decision making processes has been compromised.

**[Recommendation 4.2](#) and [Recommendation 4.3](#)**

5.1.3 The WHT safeguarding nurses within the MASH make every effort to complete all relevant checks to provide information on referrals rated as 'Red', as per the Red Amber Green (RAG) rating applied by the MASH assessment team, and will telephone DWMH to request that checks are undertaken on their respective systems. However if a referral is rated as 'Amber' or 'Green' then the available checks within WHT will be carried out but contact will not automatically be made with DWMH unless there is clear rationale to do so. This creates a risk that potentially vital information held within the mental health trust is not considered during multi agency decision making in the MASH. [Recommendation 4.3](#)

5.1.4 The quality of referrals from health services into the MASH is extremely variable and evidence was seen of a large number which are returned to the referrer as inappropriate or incomplete. Records seen demonstrated some good quality referrals which clearly outlined risk and protective factors but other referrals failed to include basic details, such as the child's name or age and date of birth or a lack of discussion with the parent (where appropriate). GPs, '111' and the ED were reported to be the main referrers where quality issues were of concern. We were not assured that plans were in place to address these concerns. [Recommendation 4.1](#)

5.1.5 The increased demand within MASH, coupled with ongoing capacity issues in the newly formed WHT safeguarding and looked after children team, is significantly impacting on the delivery of the safeguarding service within the trust. The service into the MASH is not specifically commissioned and the safeguarding team are increasingly operating in a reactive way to respond to the workflow from the MASH. This is affecting their ability to drive forward practice, consistency, quality and improvements in safeguarding in a number of services. Despite best efforts quality assurance and audits are no longer undertaken by the safeguarding team and access to safeguarding specialism via supervision or bespoke training has also been reduced. This has been raised at a number of levels and will form part of the rapid refresh and review of safeguarding within the trust. [Recommendation 1.10](#)

5.1.6 Due to the insufficient health resource allocated to the MASH there has been a considerable impact on the looked after children's team's capacity to provide the right level of support to children who are looked after, as detailed above. The amalgamation of the safeguarding and looked after children's health team combined with ongoing changes to staffing and structures within the looked after children's health team have led to a period of instability around remits and posts which are compounded by competing priorities and increasing workload pressures. Commissioners are aware of the capacity issues in the safeguarding and looked after children's team however currently there is no agreed plan in place to address these concerns. [Recommendation 1.10](#) and [Recommendation 5.1](#)

5.1.7 The CSE risk assessment tool based on 'Spotting the signs' available through the WHT trust website is not used routinely across services within the trust. This is a missed opportunity to aid early identification of children and young people at risk of being exploited and does not support the health focussed CSE work identified as one of the priorities in the 2017/18 work programme as cited in the safeguarding annual report 2016/17. [Recommendation 1.7](#)

5.1.8 The WISH service are well linked in with the Local authority CSE strategy attending and providing training across the Walsall economy. They have developed comprehensive risk assessment tools based on combining the Local Safeguarding Children's Board (LSCB) toolkit alongside 'Spotting the signs'. This means practitioners are well equipped to support children and young people who are at risk of, or involved in, sexually exploitative behaviour.

5.1.9 DWMH are well aligned with the local multi-agency CSE strategy and are working to strengthen arrangements with services. Action is being taken to raise awareness of the CSE risk assessment tool by making this more accessible to staff through the intranet. The trust is also ensuring that all staff know the reporting process so that once concerns are identified they can be acted on appropriately.

5.1.10 The recent introduction of a perinatal mental health pilot in Walsall to provide pregnant women with immediate and localised access to appropriate services via community clinics is positive. This is key to ensuring that women are readily identified and able to access specialist mental health treatment to help reduce the negative impact of mental ill health. It is too early to evaluate the impact of this pilot but a permanent specialist perinatal mental health service would bring Walsall in line with NICE guidance. [Recommendation 2.4](#)

5.1.11 There are robust systems in place for health visitors to be made aware of expectant women known to midwifery. Health visitors have access to the midwifery electronic patient record system which is regularly monitored for new bookings and deliveries. Communication and information sharing between these services is good and cases seen highlighted clear information sharing and liaison processes. This helps to make sure women are linked in with public health nurses at the earliest opportunity to support ongoing continuity of care.

5.1.12 Managers within the health visiting service recognise the key role they play as part of early help intervention. Health visitors are trained to act as the 'lead professional' under early help arrangements and team leaders have completed the 'train the trainer' course to enable further delivery to multiagency teams. As a result health visiting practitioners are competent and confident in coordinating and meeting the early help needs of vulnerable children and families.

5.1.13 The school nursing service make good use of the skill mix within the team. Community staff nurses (band 5) are able to lead on safeguarding cases with oversight of school nurses (band 6). This increases the capacity to offer support to children with safeguarding concerns and also upskills staff nurses under the supervision of qualified school nurses.

5.1.14 The recently appointed named doctor for safeguarding in WHT reports being well supported by the designated doctor with whom he meets regularly. A work plan has been developed for the next 12 months to clarify priorities and actions needed to be carried out to achieve good outcomes.



5.1.15 DWMH have established a dedicated safeguarding admin post to improve consistency and ensure safeguarding processes are resourced appropriately within the trust. CAMHS leads report that this has improved the efficiency of safeguarding processes by providing a centralised point for all safeguarding information.

5.1.16 There is a lack of clarity about safeguarding referrals made by the CAMHS service into the MASH. Evidence was seen of a safeguarding database in CAMHS which showed approximately 10 referrals a month submitted to the MASH. This is in contrast to information from the MASH, anecdotally and referral data, which indicates that there have been zero referrals from CAMHS in the last 12 months. This is a significant disparity in information.

5.1.17 Multiagency working within CAMHS has been strengthened via representation on a number of strategic and operational partnership boards. This has improved lines of communication and promoted alignment and a greater understanding of priorities within the local area, which benefit children and young people accessing the service.

5.1.18 Practitioners and leads within The Beacon service acknowledged that more could be done to ensure that information from a senior management level is cascaded to front line staff. This is important for a smaller, relatively new provider, to ensure there is appropriate representation to enable connections to be made promoting formalised pathways and joint working protocols. The impact seen in the service was that multi agency working is underdeveloped. We saw pockets of strong practice, such as with the specialist pregnancy and family workers, but it was not consistent throughout the service. This was acknowledged by team leads as an area they intend to progress, specifically with adult mental health, CAMHS, and public health nurses. Improved engagement would aid early intervention and promote a more joined up approach to supporting clients and their children. [\*\*Recommendation 6.1\*\*](#) *This area for development has been brought to the attention of Walsall Public Health as the commissioner of The Beacon substance misuse service.*

5.1.19 We saw a strong drive, leadership and oversight of safeguarding practice by the lead GP, clinical summariser and safeguarding administrator in the one GP practice visited. The lead GP for safeguarding within the practice was visible and provided a good level of advice and support to the surgery in dealing with complex cases.



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## 5.2 Governance

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5.2.1 Within Walsall the array of electronic, paper and hybrid systems, which use a combination of both electronic and paper records, present a significant challenge to the effective sharing, and accessing of, information as the systems do not interface with each other. Given that the health practitioner based within the MASH is provided by WHT, access is not available to systems used by DWMH, GPs or The Beacon service. Furthermore despite the WISH service being provided by WHT there is no access to their electronic patient record system. These additional barriers all contribute to protracting the process to obtain timely, relevant information to inform decision making in the MASH. [Recommendation 4.3](#)

5.2.2 Some of the four health systems in the MASH accessed by the WHT safeguarding nurses are configured as 'read only' and therefore updates cannot always be saved on a child's or parent's record. This is in contradiction to the MASH operating principles which state that actions from referrals made to the MASH will be recorded on health systems. This means that frontline practitioners working with families may not be sighted on current risks as information has not been loaded onto their service's specific electronic patient record system. [Recommendation 4.3](#)

5.2.3 The WHT safeguarding corporate lead acknowledges that due to capacity pressures, the safeguarding team, including the named midwife, have been unable to undertake any quality audits, such as routine enquiry of domestic abuse, or quality assurance of referrals from trust practitioners across services. Consequently within the hospital there is no quality assurance of referrals to MASH completed by ED or maternity practitioners undertaken prior to their submission to ensure best practice in articulating the risk of harm to the child to facilitate good decision making. Furthermore opportunities to strengthen governance through the introduction of quality assurance processes led by operational managers in these frontline services prior to the submission have been missed. [Recommendation 4.1](#)

5.2.4 Record keeping in midwifery is inconsistent and requires greater management oversight. In the majority of files sampled, contacts were recorded comprehensively in notes however some were missing important details regarding child protection status or entries were duplicated on several occasions. It is unclear whether this is due to a specific gap in training around the use of the electronic patient record system, or whether there are individual issues with practitioner record keeping standards. [Recommendation 1.6](#)

5.2.5 The recent decommissioning of an electronic child health system in April 2017, with no contingency measures to ensure safe transfer of records or assessment of the impact of practice within public health nursing, is a significant risk. The electronic alerts on records in this system flagged additional vulnerabilities, child protection proceedings and looked after status ensuring practitioners were fully aware of additional risks or enhanced support families required. However access to this electronic system has now been removed meaning health visitors are no longer fully informed of vulnerabilities and therefore unable to use this information as part of an ongoing risk assessment. In the absence of a centralised comprehensive electronic system, each separate health visiting team has created their own safeguarding spreadsheet in an attempt to 'flag' any children with safeguarding concerns. These spreadsheets are not accessible across the different health visiting teams in Walsall and do not provide assurance that oversight of safeguarding practice within the service is being monitored effectively. We were told this has been on the WHT risk register rag rated 'Red' since the system was known to be being decommissioned however there is no evidence of action taken to rectify the situation.

**[Recommendation 1.11](#)**

5.2.6 Team leaders in the health visiting service promote ring-fenced time every three months where practitioners across the service dedicate a day to allow for reflective practice discussions and also to ensure administrative tasks are carried out. This provides practitioners with an opportunity with peers to reflect on their practice and ensure any outstanding tasks are completed.

5.2.7 There is good oversight of safeguarding practice within the health visiting service by team leaders. Audits are undertaken every three months of children with known safeguarding concerns, and further dip sampling of all health visiting records is carried out every 12 months. This helps managers to gain assurance of the quality of safeguarding practice within the service and to support practitioners where practice may need strengthening.

5.2.8 The existing paper record keeping arrangements in the school nursing service do not support practitioners to have efficient and timely access to complete child health records. Whilst information such as safeguarding minutes, reports and outcome plans were part of children's records, it was difficult to navigate the volume of information held in different sections or folders and as a result safeguarding information is not highly visible. This restricts practitioners' ability to share information effectively to ensure the safety and wellbeing of vulnerable children and the increases the risk of key information being missed or not being immediately accessible to practitioners and managers. **[Recommendation 1.6](#)**

5.2.9 Within school nursing the system to check and cross pollinate safeguarding minutes and reports between records requires strengthening. This was evidenced during our case tracking of children from a large sibling group where concerns about one sibling were found in safeguarding minutes retained in different sibling's file, but had not been cross pollinated to all siblings' records. This means the school nursing service does not always have a complete record which restricts oversight of current and historic safeguarding concerns of children in large sibling groups.

**[Recommendation 1.6](#)**

5.2.10 Records in Walsall Manor hospital demonstrated good visibility of children known to be at risk or looked after via flagging on the hospital patient record system. The flagging alerts are managed and updated by the trust safeguarding team which helps to support effective safeguarding risk assessment within the department as well as prompting clinicians to notify Children's Social Care of a child's attendance and to liaise promptly with case workers.

5.2.11 At WHT, clinical managers in the ED and the trust executive have no means of gathering data for an overview of the cohort of hidden children linked to adults attending the ED for treatment. Therefore the trust board cannot be assured as to how effective the adult ED is in safeguarding children from hidden harm on a day to day basis due to the limitations of the IT system and the assessment documentation that is currently in use. The documentation has recently been revised however, the opportunity to strengthen safeguarding risk assessment practice through the inclusion of appropriate mandatory information fields, safeguarding prompts and trigger questions has been missed. [Recommendation 1.12](#)

5.2.12 The re-introduction of a paediatric liaison role in WHT working across the interface between the acute and community services is positive; giving the potential to strengthen safeguarding governance arrangements which are currently underdeveloped in the trust. The role is acting as an effective conduit to promote follow-up actions by community health practitioners after a child's attendance at the ED. However, potential benefits of this role are undermined by difficulties securing a permanent base within the hospital which inhibits multi-disciplinary quality assurance and more robust operational management oversight of safeguarding risk assessment practice. Further limitations such as poor access to up to date scanned clinical ED records restricts the ability to review safeguarding risk assessment and act promptly to address any sub-optimal practice to support continuous improvement.

5.2.13 The WHT paediatricians peer review process has been strengthened recently under the leadership of the trust's new named doctor for safeguarding. Meetings are more formalised and minuted and there are plans to benchmark in accordance with Royal College guidance. This is positive progress.

5.2.14 There is good join up of electronic patient record system to monitor young people who present at different WISH settings. The contraception and sexual health services are linked by a common IT system which enables people attending multiple sites to be readily identified. The WISH team also have access to hospital electronic records which aids oversight of a young person's access to health services. This arrangement could be strengthened by the use of chronologies which would help practitioners to identify cases where risks are emerging encouraging prompt action to be taken. *This area for development has been brought to the attention of Walsall Public Health as the commissioner of the WISH service.*

5.2.15 In DWMH, safeguarding and patient safety is well established within a single portfolio under the director of patient safety and compliance clinical governance manager. This streamlined and made more clear lines of safeguarding accountability within the trust. The safeguarding strategic group reviews local and national reports and serious case reviews (SCR) and disseminates lessons learned or key messages.

5.2.16 Within CAMHS there are effective methods to ensure oversight of children and young people in service. There are good frontline safeguarding governance arrangements and managers routinely review caseloads and appropriateness of children and young people accessing service with. This ensure that practitioners are working effectively and efficiently to meet the needs of their client group as a whole.

5.2.17 In DWMH mental health services for adults and young people there are processes in place to quality assure referrals made to the MASH. Practitioners discuss the referral with a lead within the service to check the quality and clarity of the referral prior to submission. An alert is also generated and sent to the internal safeguarding team providing oversight of all referrals. Within CAMHS this positive practice facilitates quality assurance at an operational level helping to support continuous practice improvement. However, safeguarding referrals reviewed in the adult mental health service were variable in quality with the circumstances prompting the referral not always clearly articulated. [Recommendation 4.1](#)

5.2.18 In CAMHS and adult mental health services managerial monitoring of case recording and record keeping is underdeveloped. This was highlighted in cases where risk assessments and care plans were absent or out of date in CAMHS and child protection/looked after children status was unclear in adult mental health services. Poor record keeping restricts managers assurance that practitioners are working effectively to risk assess and safeguarding children. [Recommendation 3.2](#)

5.2.19 In DWMH, the electronic case recording system does not support adult mental health practitioners well in their work to safeguard children. There are limitations in recording basic demographic information about children within the family or household so the presence of children is not immediately clear to managers or practitioners opening the case record. This increases risks that the potential for hidden harm to children will be missed. [Recommendation 3.2](#)

5.2.20 Oversight of vulnerable children attached to adult mental health service user is an area for development. Team managers do not hold a database setting out the cohort of children overall in service, or those subject to early help, child in need, child protection processes or children who are looked after. This does not help the trust to monitor child safeguarding activity and practice over time or support operational managers in their safeguarding practice governance, caseload management and workforce skills profiling. [Recommendation 3.3](#)

5.2.21 The adult mental health service does not use chronologies which help highlight key child protection events in adult patient case records. Given the limitations of the electronic case recording system used in DWMH, use of chronologies would benefit both practitioners and operational managers in setting out and monitoring key events relating to the protection of individual children on the adult case record. [Recommendation 3.2](#)

5.2.22 In-patient case recording in DWMH Dorothy Patterson Hospital is good with detailed and comprehensive entries dated and signed by clinicians. This was particularly evident in one highly complex case involving multiple agencies and local authority areas. This supports effective accountability and ensures that accurate records are held on the patient's file.

5.2.23 Records seen in The Beacon service showed a good standard of record keeping utilising new integrated 'live' risk assessment and care plans. The new model of case note recording requires practitioners to review risks at every contact with a comprehensive assessment carried out every 12 weeks. This encourages a more structured and outcome focussed approach to the delivery of interventions.

5.2.24 The development of the dedicated safeguarding lead in The Beacon service to improve safeguarding arrangements is a strength. Quality assurance of all referrals to the MASH is undertaken prior to submission and the quality of contributions to child protection proceedings is maintained via a standardised template. The safeguarding lead submits all reports to Children's Social Care acting as a single point of contact for safeguarding practice and completes regular audits to shape training delivered to staff in order to improve practice. There are effective methods of monitoring safeguarding processes via a comprehensive safeguarding spreadsheet which monitors the progress of all MASH and MARAC referrals. This also includes the due dates for client risk assessments to provide assurance that safeguarding referrals do not get lost in the system and that risks are regularly reviewed. This role promotes good quality safeguarding work and ensures that practitioners are aware of their responsibilities in relation to child safeguarding.

5.2.25 The one GP practice visited utilised systems well to ensure safeguarding activity was accurately captured. Records demonstrated clear systems and processes in place for appropriate flagging, updating and reviewing of the coding of children, including those who are in need and those supported at the early help level. Recognition of the risks posed by, and vulnerabilities of, adults within the household was evident with appropriate linking of information between parent and children's records. As a result this practice has good oversight and awareness of safeguarding activity for vulnerable families in their care.

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## 5.3 Training and supervision

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5.3.1 Whilst all services we visited had clear expectations for training and supervision, current arrangement and compliance in Walsall Manor hospital services and The Beacon service are not meeting intercollegiate guidelines. Much of the training is delivered on an in-house basis and despite multi agency content, is not delivered to a multi-agency audience therefore practitioners are not exposed to a learning environment which would aide a more in-depth comprehensive understanding of safeguarding children from a variety of professional perspectives. **Recommendation 4.4** *This area for development has also been brought to the attention of Walsall Public Health as the commissioner of The Beacon substance misuse service.*

5.3.2 As mentioned previously the significant capacity issues in the safeguarding and looked after children's team have restricted the ability of safeguarding nurses to provide safeguarding supervision to a number frontline staff or managers across WHT. This means we cannot be assured that the appropriate support mechanisms are in place to ensure needs and competencies are met when supporting practitioners with complex cases. **Recommendation 1.10**

5.3.3 The WHT safeguarding and looked after children's health team have undertaken appropriate levels of training in line with guidance, level four safeguarding children training which provides the skills and competence to carry out safeguarding supervision.

5.3.4 Looked after children's practitioners have access to regular group safeguarding supervision however do not feel this meets their needs and have requested this is changed. Supervision arrangements are in their infancy due to new post holder in CCG who will provide one-to-one supervision, therefore it is too early to assess impact of this.

5.3.5 Team leaders within midwifery promote the professional development of practitioners by disseminating learning to frontline staff. Key staff have accessed multi-agency safeguarding training on a range issues delivered by the LSCB and cascade information and good practice to midwifery teams to promote good working practice.

5.3.6 Walsall Manor hospital staff have good access to female genital mutilation (FGM) training to meet the needs of the changing demographic of the area. FGM is becoming more prevalent in Walsall and as a result specific midwifery training has been put in place with support and advice from an FGM survivor. This is a good example of consultation and co-production. The FGM pathway is robust and includes automatic referral into the MASH at booking in case mother has a female child to ensure their safety is maintained.



5.3.7 Formal supervision arrangements in midwifery are in place to support practitioners. Community team leaders have completed supervisor training which has equipped them to provide midwives with access to quarterly individual supervision. Ad hoc advice and guidance is readily available by phone and email from both the named midwife and team leaders which is formally recorded in patient notes.

5.3.8 There is a solid training offer to support public health nurses in delivering safe practice. There is good compliance with safeguarding children level three and all frontline practitioners have access to training on a range of additional topics such as FGM, disguised compliance, CSE and the impact of domestic abuse on the child. This leads to an informed workforce skilled in meeting the needs of children and young people.

5.3.9 The graded preceptorship that exists in health visiting provides good support for practitioners developing their skills and knowledge in safeguarding. One newly qualified health visitor informed us that this is targeted and supportive. This provides a high level of support for new staff resulting in more confident practitioners able to identify, assess and meet the needs of children and families.

5.3.10 Safeguarding supervision for front line public health nurses is robust. Operationally health visitors and school nurses access regular one-to-one safeguarding supervision facilitated by a team leader on a quarterly basis. This includes discussion, reflection and analysis around risk and protective factors for the child with actions and timescales agreed. Safeguarding supervision paperwork is completed and sent to the safeguarding team however, as previously mentioned, team leaders report difficulty accessing support for their own safeguarding supervision.

5.3.11 Young people benefit from a well-trained WISH workforce as practitioners have accessed additional training such as FGM, forced marriage, CSE, and domestic abuse to ensure up to date knowledge. Furthermore administration staff have been trained on position of power to allow informed observations of waiting areas. This training adds significant value to the risk assessment of vulnerable individuals to promote effective safeguarding.

5.3.12 Formal safeguarding supervision arrangements are in place within the WISH service. Staff report they have good access to ad hoc advice and support on request from the named team, in addition to a formal regular slot for safeguarding supervision from trust team. As a result practitioners feel well supported whilst working with vulnerable and risky young people.

5.3.13 There are no safeguarding supervision arrangements in place in the ED, PAU and paediatric wards and no routine access to individual safeguarding supervision for paediatricians. This is particularly pertinent to frontline staff who are supporting children at significant risk of self-harm on a day-to-day basis in the PAU and paediatric ward. The Trust's safeguarding team lead recognises this as an area needing development. [Recommendation 1.10](#)

5.3.14 Since the last CQC inspection of Walsall Manor Hospital ED, action has been taken to increase the provision of paediatric trained nurses to ensure a presence on all shifts at all times. The matron gave us assurance that compliance is good and any exceptions are reported as incidents to senior management. This is positive progress to ensure that children and young people are seen by appropriately trained practitioners.

5.3.15 The matron and senior sisters on the PAU and paediatric wards are proactive in seeking out appropriate professionals to provide mental health training to meet the needs of hospital staff supporting young people, often at significant risk of serious self-harm. Discussions are in hand between iCAMHS and the PAU senior staff to identify how iCAMHS can further support mental health training and development in the ward.

5.3.16 In DWMH all adult and children's mental health frontline practitioners are trained to level 3 child safeguarding and this training routinely includes attendance at the LSCB multi-agency training covering a variety of relevant topics. Compliance is monitored closely within the trust which ensures that practitioners are skilled in safeguarding practice.

5.3.17 Practitioners within CAMHS report benefitting from a robust supervision model, receiving individual clinical and management supervision and group complex case and reflective practice supervision on a regular basis. The team also offer supervision to Local Authority partners who require clinical supervision. This means that practitioners have good opportunity to discuss children of concern and seek advice and support where necessary.

5.3.18 Operational managers in adult mental health are trained to safeguarding children level three but have not received additional safeguarding supervisory training to quality assure and monitor child safeguarding practice in frontline services. Managers would benefit from enhanced child safeguarding training and safeguarding supervision to ensure they know what best practice looks like and are equipped to identify and address poor or sub-optimal practice effectively.

#### **[Recommendation 4.4](#)**

5.3.19 Adult mental health practitioners receive one-to-one supervision every three months from their clinical supervisor. This includes child safeguarding as a standard agenda item however, it was not clear how challenging the supervision is and whether it is best supporting continuous improvement.

5.3.20 There is an audit and learning culture within The Beacon service. Practitioners are engaged in weekly service meetings containing learning sessions to promote ongoing development of staff and the service on a variety of topics. However despite the positive in-house training offer, the service is not fully compliant with safeguarding training in line with intercollegiate guidance as mentioned above.



5.3.21 The Beacon service support the upskilling of multiagency colleagues by providing training to professionals via the Walsall LSCB. The Beacon have delivered parental substance misuse training in addition to holding a safeguarding day in an attempt to improve gaps in knowledge and professional understanding of the risks to children when parents use substances.

5.3.22 Within The Beacon practitioners and managers both receive regular line management and case management supervision with the option for reflective practice and learning on a monthly basis. There has been a recent revision to the supervision model however it is too early to evaluate the impact.

5.3.23 In the one GP practice visited all GPs and front line practitioners had undertaken level three training in safeguarding children in line with intercollegiate guidance and accessed relevant additional training such as FGM. Support staff had all undertaken level one and two safeguarding training to provide a basic understanding of safeguarding practice.

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# Recommendations

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## 1. Walsall Health Care Trust should:

- 1.1 Ensure that expectant women benefit from robust risk assessment in the ante natal period to identify and support vulnerability.
- 1.2 Improve Emergency Department notification processes to include sufficient detail on any safeguarding or follow up action required by primary care.
- 1.3 Ensure that children and young people who attend the ED and are waiting for treatment are visible to staff.
- 1.4 Ensure that children and young people who attend the ED benefit from rigorous safeguarding practices, to include prompt identification and robust assessment of risk.
- 1.5 Ensure that young people who attend the ED due to drug or alcohol use are referred to The Beacon service for support in line with agreed care pathways.
- 1.6 Assure themselves on the quality of records within midwifery, health visiting and school nursing to support practitioners to identify concerns and safeguard children and young people effectively.
- 1.7 Ensure all practitioners make full use of the trust's CSE risk assessment tool for children and young people who are vulnerable to being exploited.
- 1.8 Ensure that children who are looked after benefit from comprehensive, high quality, timely health assessments and health reviews that incorporate health information from all health professionals.
- 1.9 Work with the local authority to ensure that children looked after health assessments are informed by up to date SDQs.
- 1.10 Expedite the rapid refresh and review of safeguarding and appropriately act upon the findings.

- 1.11 Assure themselves that children and young people are not at risk following the decision to decommission the electronic child health system and where risk is present, implement appropriate measures to mitigate this as a matter of urgency.
- 1.12 Ensure that children of adults who attend the Emergency Department are identified and safeguarded effectively.

**2. Walsall Clinical Commissioning Group should:**

- 2.1 Support GPs in Walsall to develop consistent arrangements for regularly sharing information and monitoring vulnerable families' progress with community children's health services
- 2.2 Work with partners, including the police, to ensure that the crisis pathway relating to young people detained by the police is clarified and fully understood by all practitioners including the availability of a health based place of safety.
- 2.3 Work with GPs in Walsall to improve their contribution to looked after children's health assessments
- 2.4 Work with local providers to improve services for women experiencing perinatal mental health difficulties so that their care is compliant with NICE guidance.

**3. Dudley and Walsall Mental Health Partnership Trust should:**

- 3.1 Ensure that children and young people who attend CAMHS benefit from regular review of their risk.
- 3.2 Ensure that record keeping within their adult mental health and CAMHS services meet trust standards.
- 3.3 Improve the identification and recording of children associated with adult clients and ensure that all risk assessments consider the impact of the adult's mental health on their children, where appropriate.

**4. Walsall CCG, Walsall Health Care Trust and Dudley and Walsall Mental Health Partnership Trust should:**

- 4.1 Ensure that health referrals made to MASH describe the nature of the concern with an analysis of risk and protective factors to aid decision making.
- 4.2 Work together to ensure that the health role within the MASH is adequately resourced to enable full participation in MASH processes, on behalf of all health services, at all times.
- 4.3 Work together to ensure arrangements for efficient information exchange between all health providers to provide appropriate information enabling the MASH health practitioner to contribute to multiagency decision making processes in MASH
- 4.4 Ensure that practitioners are trained in safeguarding children in line with the standards outlined in the intercollegiate guidance.

**5. Walsall CCG and Walsall Health Care Trust should:**

- 5.1 Work together to ensure that the looked after children's health team is appropriately resourced to provide children who are looked after with high quality care.

**6. Change Grow Live, Walsall Health Care Trust and Dudley and Walsall Mental Health Partnership Trust should:**

- 6.1 Work with all partners to ensure that robust pathways and protocols are in place, and fully utilised, to provide adults and young people with timely referral for drug and/or alcohol support and positive multiagency working.

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## Next steps

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An action plan addressing the recommendations above is required from Walsall CCG within **20 working days** of receipt of this report.

Please submit your action plan to CQC through [childrens-services-inspection@cqc.org.uk](mailto:childrens-services-inspection@cqc.org.uk) The plan will be considered by the inspection team and progress will be followed up through CQC's regional compliance team.