

SC065679

Registered provider: Staffordshire County Council

Full inspection

Inspected under the social care common inspection framework

Information about this children's home

This home is owned by a local authority. It is registered to provide care for one child who may have experienced childhood instability which has resulted in trauma and associated complex behaviours.

The home has been without a registered manager since December 2021. There is an acting manager in place who is not yet registered with Ofsted.

Inspection dates: 4 and 5 May 2022

Overall experiences and progress of children and young people, taking into account **inadequate**

How well children and young people are helped and protected **inadequate**

The effectiveness of leaders and managers **inadequate**

There are serious and widespread failures that mean children are not protected or their welfare is not promoted or safeguarded and the care and experiences of children and young people are poor and they are not making progress.

Date of last inspection: 24 August 2021

Overall judgement at last inspection: good

Enforcement action since last inspection: none

Recent inspection history

Inspection date	Inspection type	Inspection judgement
24/08/2021	Full	Good
22/01/2020	Full	Good
01/08/2018	Full	Outstanding
23/01/2017	Interim	Sustained effectiveness

Inspection judgements

Overall experiences and progress of children and young people: inadequate

The inadequate leadership and management in this home has compromised children's safety and had a negative impact on children's experiences and progress.

The home's conditions of registration have recently been changed and the home no longer provides short breaks for children. In addition, the home has reduced the number of children who can live in the home to one child. Before this change taking place, two children were living in the home. Poor planning by managers meant that the two children were not well matched to live with each other and this resulted in several serious safeguarding incidents which put them and the staff at risk of harm.

Before one of the two children moved into the home, the manager had raised concerns about the two children living together. Despite this, senior managers decided to move the child in. This was not a child-centred or well-informed decision. The impact risk assessment completed by senior leaders before the child moved in failed to consider the complexities and risks of the child already living in the home.

Children's placement plans do not contain up-to-date information relating to their individual care. This means that staff are not provided with guidance to ensure that they can provide care that meets children's needs.

The two children have now moved out of the home. One child's placement was terminated with immediate effect and therefore he moved out in an unplanned way. This abrupt ending to his placement is likely to have had a negative impact on his emotional welfare and will have been detrimental to him being able to make a successful start at his new home.

On the day of the inspection, a child moved into the home. This was a planned move and there are clear plans in place to provide the child with support and to manage known risks.

How well children and young people are helped and protected: inadequate

Those children who were living in the home until recently were at risk of harm because staff did not have the skills or knowledge to keep them safe. In one incident, two children took a member of staff's keys, assaulted staff and caused significant damage to the home. The staff were unable to de-escalate the children's behaviours and police were called to manage the situation. This resulted in the children being arrested and held at the police station overnight.

On another occasion, a child was able to gain access to a vehicle that was parked outside the home. The child, accompanied by an unknown individual, stole the car and drove a very short distance before the car crashed. Staff who were present at

the time of the incident were unable to manage the child's behaviours or prevent him from taking the vehicle. This incident had the potential to result in serious harm.

The quality of recording following incidents is not sufficiently detailed. Managers have failed to ensure that staff provide a clear and accurate record of events. This demonstrates that management oversight of incidents is poor. This means that there are missed opportunities to learn and improve staff practice.

Managers do not ensure that staff consistently follow agreed risk assessments. This undermines the effectiveness of the strategies in place to protect children. Two children who no longer live in the home were required to be looked after by two members of staff each. However, on at least three separate occasions, there were insufficient numbers of staff to comply with this staffing ratio. The lack of staff compromised staff's ability to manage children's behaviours effectively and keep them safe.

Children's behaviour support plans lack detail and do not support staff to meet children's needs. They are not reviewed or updated on a regular basis. For example, one child's plan had not been updated despite there being changes in his behaviour. This contributes to a disorganised and chaotic approach to keeping children safe.

Following the use of a physical intervention, children are not always spoken to or given the opportunity to talk about the physical intervention. This is a missed opportunity for children's wishes and feelings to be heard and to discuss with the child why a physical intervention was needed.

When children return from being missing from the home, staff lack professional curiosity to understand where children have been. This means that the extent of children's vulnerabilities while they are away from the home is not understood by staff.

The effectiveness of leaders and managers: inadequate

The home has been without a registered manager since December 2021. However, the previous registered manager has recently returned, and she is in the process of submitting her application to Ofsted.

The manager is realistic about the areas for improvement in the home, however, management monitoring systems are not effective. For example, the manager has carried out a quality- of- care review, but this was not completed in the required timescales and a copy was not sent to Ofsted.

Following a recent serious incident, no internal review was undertaken by senior managers to identify learning. This was a missed opportunity to reflect on the strengths and weaknesses of staff practice.

The home has a core group of regular staff who know the children well. However, the home is not fully staffed, and the manager relies on agency staff to fill gaps in

the rota. This means that children do not always receive care from experienced staff who know them well.

The manager has failed to provide staff with regular supervision sessions. The lack of effective supervision means that the staff are not being provided with an opportunity to reflect on their practice and identify any further training they may need. In addition, supervision does not provide them with an opportunity to ensure that they are promoting better outcomes for the children in their care.

What does the children's home need to do to improve?

Statutory requirements

This section sets out the actions that the registered person(s) must take to meet the Care Standards Act 2000, Children's Homes (England) Regulations 2015 and the 'Guide to the Children's Homes Regulations, including the quality standards'. The registered person(s) must comply within the given timescales.

Requirement	Due date
The protection of children standard is that children are protected from harm and enabled to keep themselves safe. In particular, the standard in paragraph (1) requires the registered person to ensure— that staff— assess whether each child is at risk of harm, taking into account information in the child's relevant plans, and, if necessary, make arrangements to reduce the risk of any harm to the child; help each child to understand how to keep safe; have the skills to identify and act upon signs that a child is at risk of harm; take effective action whenever there is a serious concern about a child's welfare. (Regulation 12 (1) (2)(a)(i)(ii)(iii)(vi)) This specifically relates to the registered person ensuring that risk assessments give staff clear guidance to help them to understand risk for individual children and what to do to keep a child safe when a risk arises.	16 June 2022
The leadership and management standard is that the registered person enables, inspires and leads a culture in relation to the children's home that— helps children aspire to fulfil their potential; and promotes their welfare. In particular, the standard in paragraph (1) requires the registered person to—	16 June 2022

ensure that the home has sufficient staff to provide care for each child; use monitoring and review systems to make continuous improvements in the quality of care provided in the home. (Regulation 13 (1)(a)(b) (2)(d)(h)) This specifically relates to the registered person ensuring that they have monitoring and reviewing systems in place which identify shortfalls effectively.	
The care planning standard is that children— receive effectively planned care in or through the children’s home; and have a positive experience of arriving at or moving on from the home. In particular, the standard in paragraph (1) requires the registered person to ensure— that children are admitted to the home only if their needs are within the range of needs of children for whom it is intended that the home is to provide care and accommodation, as set out in the home’s statement of purpose; that arrangements are in place to— ensure the effective induction of each child into the home; plan for, and help, each child to prepare to leave the home or to move into adult care in a way that is consistent with arrangements agreed with the child’s placing authority; (Regulation 14 (1)(a)(b) (2)(a)(b)(i)(iii)) This specifically relates to the registered person ensuring that children are suitably matched to the home.	16 June 2022
The registered person must ensure that— within 5 days of the use of the measure, the registered person or the authorised person adds to the record confirmation that they have spoken to the child about the measure. (Regulation 35 (3)(c))	16 June 2022

This specifically relates to the registered person ensuring that debriefs are carried out with children and that these are recorded.	
The registered person must maintain records ("case records") for each child which— are kept up to date. (Regulation 36 (1)(b)) The specifically relates to the registered person ensuring that children's records are kept up to date.	16 June 2022
The registered manager must complete a review of the quality of care provided for children ("a quality of care review") at least once every 6 months. In order to complete a quality of care review the registered person must establish and maintain a system for monitoring, reviewing and evaluating— the quality of care provided for children; After completing a quality of care review, the registered person must produce a written report about the quality of care review and the actions which the registered person intends to take as a result of the quality of care review ("the quality of care review report"). The registered person must— supply to HMCI a copy of the quality of care review report within 28 days of the date on which the quality of care review is completed; and make a copy of the quality of care review report available on request to a placing authority, if the placing authority is not the parent of a child accommodated in the home. (Regulation 45 (1) (2)(a) (3) (4)(a)(b)) This specifically relates to the registered person completing the quality of care report in a timely manner.	16 June 2022

Recommendation

- The registered person should put systems in place so that all staff, including the manager, receive supervision of their practice from an appropriately qualified and experienced professional, which allows them to reflect on their practice and the needs of the children assigned to their care. ('Guide to the Children's Homes Regulations, including the quality standards', page 61, paragraph 13.2)

Information about this inspection

Inspectors have looked closely at the experiences and progress of children and young people, using the social care common inspection framework. This inspection was carried out under the Care Standards Act 2000 to assess the effectiveness of the service, how it meets the core functions of the service as set out in legislation, and to consider how well it complies with the Children's Homes (England) Regulations 2015 and the 'Guide to the Children's Homes Regulations, including the quality standards'.

Children's home details

Unique reference number: SC065679

Provision sub-type: Children's home

Registered provider: Staffordshire County Council

Registered provider address: Wedgwood Buildings, Tipping Street, Stafford, Staffordshire ST16 2DH

Responsible individual: Elizabeth Kelay

Registered manager: Post vacant

Inspector

Lydia Isaac, Social Care Inspector

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