Children's homes inspection – Full

Inspection date	**03/08/2016**
Unique reference number	**SC483710**
Type of inspection	**Full**
Provision subtype	**Children's home**
Registered provider	**Horizon Care And Education Group Limited**
Registered provider address	**Horizon Care And Education Group, Unit 12, Prospect Business Park, Longford Road, Cannock WS11 0LG**

Responsible individual	**Ann-Cheri Callow**
Registered manager	**Post vacant**
Inspector	**Mary Timms**

Inspection date	**03/08/2016**
Previous inspection judgement	**Declined in effectiveness**
Enforcement action since last inspection	**None**
This inspection	
The overall experiences and progress of children and young people living in the home are	**Requires improvement**
The children's home is not yet delivering good help and care for children and young people. However, there are no serious or widespread failures that result in their welfare not being safeguarded or promoted.	
How well children and young people are helped and protected	**Requires improvement**
The impact and effectiveness of leaders and managers	**Inadequate**

SC483710

Summary of findings

The children's home provision requires improvement because:

- The service has been without a registered manager in day-to-day charge for 61 weeks. The lack of a permanent and registered manager has had a destabilising impact on the staff team and led to weaknesses in service delivery.
- Placement planning is poor. Plans viewed were sparse and lack the necessary level of guidance for staff to ensure that needs will be fully met. Risk management planning is also weak in some areas. This raises the potential that young people's safety is not ensured.
- There is a lack of understanding across the team about national and local guidelines for children missing from care. This, alongside weakness in recording, on occasions, fails to best promote young people's safety and well-being.
- Staff have failed to respond appropriately to a recent potential safeguarding issue. While no direct poor outcome is identified, the failure to recognise and respond appropriately potentially increases young people's vulnerability. There is also a lack of understanding across the team about roles and responsibilities when young people are missing, or return from an episode of going missing.
- There are shortfalls in record keeping, and report writing is not always accurate. This highlights weaknesses in management oversight.
- Staff do not receive regular practice-related supervision. This restricts opportunity to develop improved skills and knowledge about childcare practice in the home.

The children's home strengths

- Young people have started to make progress in some areas, including becoming safer, as there has been a reduction in the number of times that they go missing.
- Young people feel listened to and able to contribute to daily care arrangements.
- Regardless of the many changes in manager since the home opened in 2015, core staff members have remained committed and welcome further service development.

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

Statutory Requirements

This section sets out the actions which must be taken so that the registered person(s) meets 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
12: The protection of children standard In order to meet the protection of children standard, the registered persons must ensure that staff— (2)(a)(iii) have the skills to identify and act upon signs that a child is at risk of harm.	01/09/2016
13: The leadership and management standard In order to meet the leadership and management standard the registered person must— (2)(a) lead and manage the home in a way that is consistent with the approach and ethos, and delivers the outcomes, set out in the home's statement of purpose; (2)(c) ensure that staff have the experience, qualifications and skills to meet the needs of each child.	01/09/2016
14: The care planning standard In order to meet the care planning standard the registered person must ensure that— (1)(a) children receive effectively planned care in or through the children's home.	01/09/2016
The registered provider must appoint a person to manage the home. (Regulation 27 (1)(a))	01/09/2016
The registered person must ensure that all employees receive practice-related supervision by a person with appropriate experience. (Regulation 33 (4)(b))	01/09/2016
The registered person must ensure that within 24 hours of the use of a measure of control, discipline or restraint in relation to a child in the home, a record is made. (Regulation 35 (3)(a))	01/09/2016

Recommendations

To improve the quality and standards of care further, the service should take account of the following recommendations:

- Evaluation of incidents of going missing should be undertaken to identify any gaps in training, skills or knowledge for staff or to record and retain evidence of what worked well. ('Guide to the children's homes regulations including the quality standards', page 46, paragraph 9.31)
- Staff should be familiar with the home's polices on record keeping and understand the importance of careful, objective and clear recording. ('Guide to the children's homes regulations including the quality standards', page 62, paragraph 14.4)

Full report

Information about this children's home

The home is operated by a large private organisation and is registered to provide care and accommodation for three children with emotional and behavioural difficulties.

Inspection date	Inspection type	Inspection judgement
14/01/2016	Interim	Declined in effectiveness
28/07/2015	Full	Requires improvement
08/06/2015	Full	Inadequate

Inspection Judgements

	Judgement grade
The overall experiences and progress of children and young people living in the home are	**Requires improvement**

Young people's progress is hindered by poor placement planning. Placement plans are very brief and lack detailed guidance and agreement about how individual needs will be met. For example, the finer detail of arranging and promoting contact was lacking for a young person living a long distance from home. Additionally, areas of support and work identified as necessary are not consistently facilitated. For example, there was a lack of clarity in a healthcare plan that stated one-to-one key worker time is to be facilitated regarding sexual health and local resources. The young person says that this has been provided, but this wasn't totally clear within records, and there was no review of the effectiveness of such work. While young people are encouraged within daily routines to take responsibility for their bedroom tidiness and to do chores around the home, individual planning lacks clarity about progression with independence. This means that care and support are often unstructured, raising the potential for needs to go unmet.

A weakness at the time of the last inspection related to a lack of structure for young people on school days. This inspection finds that staff have been proactive in seeking appropriate education placements. This resulted in one young person moving into a full-time education resource, improving his chances to learn and achieve. While the previous level of concern has reduced, again patterns have started to develop of a lack of structure to the day in the absence of formal schooling.

Young people have had restricted opportunities to settle into their placements and build attachments. One young person's placement ended shortly after the last inspection due to lack of progress being made, the young person spending large amounts of time away from the home and generally seen as not engaging in the placement. Two other young people have moved on. One young person at the request of a parent, and separately a placing team identified a young person needed a more specialised placement. On balance, a placing social worker for three young people who have used the service since the last inspection has an overall positive view of the care provided. Comments demonstrate that young people have started to develop good relationships with staff and individual areas of progress are noted. A young person requested to return to this home after a period in custody, and while this was not possible for other reasons, a placement at this home would have been the social worker's preference. This shows that professionals have confidence in the care provided.

Good health is promoted through staff arranging check-ups with a dentist and optician. There is a lack of clarity about how refusal to attend appointments is addressed with young people to ensure that their needs are met. The staff are

looking at this though, and are currently liaising with the local looked after children nurse in relation to individual needs, and to support young people to attend appointments with a GP when required. The organisation employs mental health professionals who are available for consultation, and when identified needs arise may provide direct work with young people, in agreement with placing teams.

While only one young person is currently resident, a young person recently discharged also provided feedback. Both young people confirm that they, 'like the staff'. Young people say that they feel supported and listened to and are able to contribute to daily care arrangements. Comments include: 'They helped me lots, but also let me be independent' and, 'Yes, I feel staff care about me'. Also: 'xx (member of staff) helped me to get a job, he was great'. This shows that young people feel supported and begin to develop in confidence.

Opportunities to take part in activities alongside staff are promoted, even though young people often prefer to socialise with friends in the community. A young person spoke positively about a trip to the coast and is looking forward to a trip to a theme park.

	Judgement grade
How well children and young people are helped and protected	**Requires improvement**

The service is not yet good in this area because staff do not always recognise and act on safeguarding concerns. While weaknesses are not widespread and have not impacted directly on young people, the failure to see the potential for harm in a recent event demonstrates that further staff development is required.

Procedures for occasions when young people go missing are not always followed in full. For example, there is sometimes a lack of evidence to show if the return interview has taken place. There is a lack of understanding across the team as to the difference between a police safe and well check and an independent interview. Such weakness adds to the vulnerability of young people who go missing. These shortfalls are balanced against evidence showing that some young people become safer due to a reduction in events of going missing. One young person, admitted in May 2016, with a history of going missing and associated risk-taking behaviours, has not gone missing since early June 2016. The service has ensured that the young person has a mobile phone, staff have worked with her to agree contact times when she is out and have spent time getting to know her friends.

For the most part, a safe living environment is provided. Fire safety is seen as important. Young people are taught about fire safety procedures, including engagement in fire safety drills. A maintenance team responds promptly if property repairs are required. However, food safety is not always prioritised. An example of this is that the oven is not cleaned regularly and was found in a very poor condition on the day of the inspection. Also, staff were unable to clarify whether the safety of cords on a recently purchased roller blind had been considered or

checked. During the inspection, the interim manager confirmed that this would be done prior to the blind being fitted.

Physical interventions are rarely used, with only one such event in the last 12 months. Sanctions are also only used sparingly. The few sanctions recorded are appropriate responses to the behaviour. For example, a young person having an activity curtailed in response to negative behaviours. However, consequences to negative behaviours are not always captured in records. Financial records show that money has been stopped from a young person as a sanction, with no reference to this in the sanction records, required by regulation. While only one such example is noted, this highlights weaknesses in management oversight of behaviour management strategies, necessary to support desired improvements in behaviour.

The organisation has restrictions in place in relation to young people's internet access. A weakness identified is the lack of individual planning and risk management in relation to internet use though. While no detrimental impact was identified, it is apparent from discussions with a placing team that there is a lack of clarity about expectations and protection strategies relating to one young person.

Young people feel safe and confirm that staff talk to them about protective behaviours, also that they would talk to staff if they had something worrying them. One young person said: 'They have helped me with my anger management. I am much better now.' A social worker reported that: 'xx (young person) did not offend at all during his placement, compared to weekly issues previously.'

	Judgement grade
The impact and effectiveness of leaders and managers	**Inadequate**

There is a direct link between the weaknesses identified at this inspection and the quality of leadership and management. The shortfalls identified demonstrate that the service is not broadly achieving the aims and objectives set out in the statement of purpose. The service has been without a registered manager for 61 weeks. A permanent manager was recruited, started work in the home in January 2016 and subsequently applied to Ofsted for the role of registered manager. This planned permanency in management introduced a settled period, during which time areas of service development were introduced. However, this individual resigned prior to a decision about his registration being finalised. Over recent months there have been interim management arrangements put in place. The rate of change has had a negative impact on the small staff team. They have remained committed to their roles, but are weary with the adjustments in management and associated lack of stability. Because of the instability of management, the provider has made the decision to restrict the number of residents to one, on a voluntary basis. This shows that the provider recognises that there are weaknesses in service

arrangements.

Shortfalls in leadership and management include a failure to provide regular one-to-one staff supervision. This means that staff are not receiving the guidance and direction that they need to ensure that they have the skills and knowledge to meet individual and service needs to the appropriate standard.

Some progress has been made with requirements set at the time of the last inspection. Notifications to relevant agencies have been made in line with requirements, although there was a delay the week before the inspection in an issue being reported to relevant agencies. This was because staff failed to recognise the safeguarding element of the issue. Following the last inspection, actions to improve the structure to the day for young people not in full-time education were implemented. The effectiveness of this has been varied. One young person continued to refuse to engage in his placement, including in education. The other resident at the time commenced and engaged in a programme of education at a school run by the organisation operating the home. The steps taken to ensure that young people wake, get up and engage in meaningful activities is not always successful. This shortfall is linked to weaknesses in placement planning and leadership and management. Action was taken following the last inspection to reduce the use of agency staff and to ensure that when used core areas of training had been provided. This inspection finds additional weakness in staff practice. For example, a lack of management oversight has meant that poor record keeping and inaccurate report writing has gone unchecked.

The organisation has a dedicated training manager who supports staff development with a structured induction programme and refresher training at appropriate intervals. The one member of staff yet to complete a relevant level 3 qualification is working through the final modules.

The requirement set at the time of the last inspection about staff skills has been repeated. The shortfalls identified are accepted by the provider, who has immediately taken actions to improve practice in the home. For example, the provider has held an impromptu staff meeting and each member of staff received supervision in the days following the inspection. Ofsted are reassured by the action plan and the commitment to improvement shown by the provider.

What the inspection judgements mean

The experiences and progress of children and young people are at the centre of the inspection. Inspectors will use their professional judgement to determine the weight and significance of their findings in this respect. The judgements included in the report are made against 'Inspection of children's homes: framework for inspection'.

An **outstanding** children's home provides highly effective services that contribute to significantly improved outcomes for children and young people who need help and protection and care. Their progress exceeds expectations and is sustained over time.

A **good** children's home provides effective services that help, protect and care for children and young people and have their welfare safeguarded and promoted.

In a children's home that **requires improvement**, there are no widespread or serious failures that create or leave children being harmed or at risk of harm. The welfare of looked after children is safeguarded and promoted. Minimum requirements are in place. However, the children's home is not yet delivering good protection, help and care for children and young people.

A children's home that is **inadequate** is providing services where there are widespread or serious failures that create or leave children and young people being harmed or at risk of harm or that result in children looked after not having their welfare safeguarded and promoted.

Information about this inspection

Inspectors have looked closely at the experiences and progress of children and young people living in the children's home. Inspectors considered the quality of work and the difference adults make to the lives of children and young people. They read case files, watched how professional staff work with children, young people and each other and discussed the effectiveness of help and care given to children and young people. Wherever possible, they talked to children, young people and their families. In addition, the inspectors have tried to understand what the children's home knows about how well it is performing, how well it is doing and what difference it is making for the children and young people who it is trying to help, protect and look after.

This inspection was carried out under the Care Standards Act 2000 to assess the effectiveness of the service 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'.

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