

1159385

Registered provider: Cambian Childcare Limited

Full inspection

Inspected under the social care common inspection framework

Information about this children's home

This is a privately owned home registered to provide care and accommodation for up to four young people. It provides a minimum 12-month, full-time treatment programme for children and young people who have experienced or are at risk of sexual exploitation.

No registered manager has been in post since October 2018. The current manager is in the process of registering with Ofsted.

Inspection dates: 15 to 16 May 2019

Overall experiences and progress of children and young people, taking into account	inadequate
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How well children and young people are helped and protected	inadequate
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The effectiveness of leaders and managers	inadequate
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There are serious and/or widespread failures that mean children and young people are not protected or their welfare is not promoted or safeguarded, and/or the care and experiences of children and young people are poor and they are not making progress.

Date of last inspection: 2 October 2018

Overall judgement at last inspection: good

Enforcement action since last inspection: none

Recent inspection history

Inspection date	Inspection type	Inspection judgement
02/10/2018	Full	Good
27/02/2018	Interim	Improved effectiveness
27/07/2017	Full	Good
22/11/2016	Full	Requires improvement

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 children's views, wishes and feelings standard is that children receive care from staff who— take their views, wishes and feelings into account in relation to matters affecting the children's care and welfare and their lives. (Regulation 7(1)(c))	24/06/2019
In particular, the standard in paragraph (1) requires the registered person to ensure— that staff— are provided with supervision and support to enable them to understand and manage their own feelings and responses to the behaviour and emotions of children, and to help children to do the same. (Regulation 11(2)(a)(x))	24/06/2019
The leadership and management standard is that the registered person enables, inspires and leads a culture in relation to the children's home that— promotes their welfare. In particular, the standard in paragraph (1) requires the registered person to— 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; ensure that staff work as a team where appropriate; ensure that staff have the experience, qualifications and skills to meet the needs of each child; ensure that the home's workforce provides continuity of care to each child; understand the impact that the quality of care provided in the home is having on the progress and experiences of each child and use this understanding to inform the development of the quality of care provided in the home; demonstrate that practice in the home is informed and improved by taking into account and acting on— use monitoring and review systems to make continuous improvements in the quality of care provided in the home. (Regulation 13(1)(b)(2)(1)(a)(b)(c)(e)(f)(g)(h))*	24/06/2019
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	24/06/2019

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. (Regulation 14(1)(a)(b)(2)(a))	
The following measures may not be used to discipline any child— a child's contact with parents, relatives or friends. (Regulation 19(2)(i))	24/06/2019
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 which includes— the name of the child; details of the child's behaviour leading to the use of the measure; the date, time and location of the use of the measure; a description of the measure and its duration; details of any methods used or steps taken to avoid the need to use the measure; the name of the person who used the measure ("the user"), and of any other person present when the measure was used; the effectiveness and any consequences of the use of the measure; and a description of any injury to the child or any other person, and any medical treatment administered, as a result of the measure; within 48 hours of the use of the measure, the registered person, or a person who is authorised by the registered person to do so ("the authorised person")— has spoken to the user about the measure; and has signed the record to confirm it is accurate; and 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)(a)(i)(ii)(iii)(iv)(v)(vi)(vii)(viii)(b)(i)(ii)(c))	24/06/2019
The registered person must maintain records ("case records") for each child which— include the information and documents listed in Schedule 3 in relation to each child. (Regulation 36(1)(a))	24/06/2019
Schedule 4 sets out the other information that the registered person must keep in relation to a children's home. The registered person must— maintain in the home the records in Schedule 4. (Regulation 37(1)(2)(a))	24/06/2019
The registered person must review the appropriateness and suitability of the location of the premises used for the purposes of the children's home at least once in each calendar year, taking into account the requirement in regulation 12(2)(c) (the protection of children standard). When conducting the review,	24/06/2019

the registered person must consult, and take into account the views of, each relevant person. (Regulation 46(1)(2))	
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*These requirements are subject to a compliance notice.

Recommendations

- Ensure that when a child returns to the home after being missing from care or away from the home without permission, the responsible local authority must provide an opportunity for the child to have an independent return home interview. Homes should take account of the information provided by such interviews when assessing risks and putting arrangements in place to protect each child. ('Guide to the children's homes regulations including the quality standards', page 45, paragraph 9.30)

Inspection judgements

Overall experiences and progress of children and young people: inadequate

Poor matching of young people has led to young people's placements coming to a sudden end. Managers have failed to effectively consider the compatibility of young people living in the home. For example, one young person's referral documentation stated that they required a solo placement, two-to-one staffing and an awake night member of staff to manage the risks. The young person was admitted to the home with two other young people already in placement and suggested staffing levels were not considered. As a result, the young person's placement ended in an unplanned way.

Young people's continuity of care is significantly compromised because of a shortage of staff due to sickness and staff leaving. The home currently has six staff vacancies, which leaves the care of young people at risk.

Staff are disproportionate in the way that they apply sanctions. For example, one young person was told she would be given a 45-minute delay before she could see her family. Staff issued this sanction because of an incident that had happened the previous evening. Staff had recorded in the sanction record that the measure was used 'to reflect the time she had wasted the previous night'. The sanction was reviewed and agreed by a manager as an appropriate sanction. No one had challenged this decision or considered that this form of discipline had imposed a restriction on a child's right to family contact.

The home is decorated to a good standard. However, all staff that the inspector spoke to said that they felt frustrated about the lack of consultation before the redecoration commenced. One young person also raised the same concern. This shows a disregard for consulting with those who live and work in the home.

Young people know how to complain and have used the complaints process. However,

resolutions of complaints and recommended actions are not always followed through. This response to complaints does not make young people feel that they are valued and does not allow their voices to be heard in a meaningful.

Young people have made some progress from their starting points. One young person has increased her school attendance and is settled.

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

Leadership and management oversight of the home is weak. For example, on 4 April 2019, an incident took place in the home. The manager reported that one young person was restrained on two occasions during the incident. However, written logs do not reflect this. Staff have not been debriefed on the incident and no lessons have been learned so that practice can be improved. The incident was not reviewed or challenged by managers. A safeguarding investigation is currently being conducted in relation to this incident.

Risk management plans do not always provide clear guidance for staff and can differ from the verbal guidance given by managers. This confusion contributed to a young person going missing from home, and later led to an unplanned end to her placement. The member of staff who had failed to follow the manager's instructions continues to work at the home, with minimal supervision.

Managers fail to challenge young people's placing authorities to ensure that they are offered a return home interview when they have been missing from care. This failure to challenge means that staff miss the opportunity to understand why a young person has been in a situation of potential or actual risk of harm.

Staff lack the necessary skills and confidence to manage the needs and behaviours of some of the young people. For example, when a young person was found to be misusing aerosols, staff did not know what to do and had to contact an on-call manager to seek advice. Only after receiving this advice did the staff decide to remove the aerosol from the young person.

On two separate occasions, some members of staff have chosen to leave the home in the middle of an incident. This left a reduced number of staff on the premises trying to manage challenging situations. The decision taken by some staff members to leave the home compromised the safety of the remaining staff and young people.

Staff have not received training to inform them about how they can keep young people safe from radicalisation. This is despite one young person being known to be at risk of radicalisation.

The home's safe area report lacks any evidence of other professionals being consulted and does not give sufficiently detailed information about risks within the area. This stops the staff from having adequate knowledge of the potential risks that the local area poses for young people in their care.

The effectiveness of leaders and managers: inadequate

Since the registered manager left in October 2018, there has been a significant decline in the quality of care.

Senior managers have been too slow to identify this decline in the quality of care. Monitoring and review systems have also, until recently, failed to identify and address wide-ranging shortfalls. Despite concerns now being acknowledged, managers have continued to accept new referrals and have planned for new admissions to the home.

Although the leadership team has now begun to recognise the shortfalls in the home and has implemented an action plan, this plan is still in its infancy and has not yet been reviewed.

Staff morale is low, and leaders and managers have not done enough to give the staff the support and help they need to improve their practice. This failure has left poor practice unchallenged.

This is further compounded by the lack of supervision provided for staff. The manager reported that staff had not been supervised until she was appointed in February. One member of staff has had one supervision since September 2018. Another staff member has refused supervision due to feeling frustrated at the lack of impact it has. The impact of such poor management is that staff have low levels of confidence in the effectiveness of supervision to help them to review and develop their practice.

Staff have completed basic mandatory training. However, staff still lack the necessary skills and confidence to manage the needs of some of the young people who have lived in the home. Only two members of staff are qualified to the required standard of having a level 3 diploma in residential childcare, including the manager. Four members of staff have not achieved the qualification within the set time period of two years. This has resulted in a repeated breach of regulation.

The inspector was not able to access all of the staff rotas. This was because the previous manager held some of these records. This compromises the organisation's ability to access records that confirm which staff have worked at the home.

Communication between the manager and other senior leaders is poor. The manager has not always been kept up to date with important information, and has not agreed with some decisions made. This has impacted on her ability to manage the home effectively.

Information about this inspection

Inspectors have looked closely at the experiences and progress of children and young people. Inspectors considered the quality of work and the differences made to the lives of children and young people. They watched how professional staff work with children

and young people and each other and discussed the effectiveness of help and care provided. Wherever possible, they talked to children and 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 whom it is trying to help, protect and look after.

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: 1159385

Provision sub-type: Children's home

Registered provider: Cambian Childcare Limited

Registered provider address: 4th Floor, Waterfront, Manbre Wharf, Manbre Road, Hammersmith, Middlesex W6 9RU

Responsible individual: Michael Ore

Registered manager: Post vacant

Inspector

Lisa O'Donovan: social care inspector

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