

Communities and Culture Committee

CC(3) YJ17

Committee Inquiry into Youth Justice in Wales – evidence gathering – Care and Social Services Inspectorate Wales

The purpose of this paper is to provide the committee with information regarding

- **Care Social Services Inspectorate Wales (CSSIW)**
- **The role of CSSIW in the Youth Justice services**
- **The issues raised in the terms of reference for the inquiry**

CSSIW welcomes the committee's inquiry and the opportunity to provide written and oral evidence. We would be pleased to provide the committee with any further information that may be of assistance.

Background

- On 1 April 2007, the Care Standards Inspectorate for Wales (CSIW) and the Social Services Inspectorate for Wales (SSIW) and their respective functions and powers were brought together to form the Care and Social Services Inspectorate Wales (CSSIW).
- The Health and Social Care (Community Health and Standards) Act 2003 gives CSSIW its powers to review the way in which local authorities discharge their social services functions.
- The Care Standards Act 2000, The Children Act 1989 (as amended) and The Adoption and Children Act 2002 give powers to register and inspect establishments and agencies in Wales that provide social care.

Youth Justice Services --The role of CSSIW

Context --Youth Justice Services in Wales

- Criminal justice services remain with the UK Government. Performance is monitored through the Youth Justice Board but local authority services, including children's services, are financed and held to account by the Welsh Assembly Government. The All-Wales Youth Offending Strategy (2004) was developed between the Welsh Assembly Government and the Youth Justice Board as a joint statement of intent in relation to Youth Justice in Wales. The Welsh Assembly Government has adopted the UN Convention on the Rights of the Child as the basis for all its work with and on behalf of children and young people. The Convention is expressed in seven Core Aims that form the basis for implementation of the Children Act 2004 in respect of Children and Young People's Plans and all other policy developments
- The Inspection of the Youth Justice Service is undertaken by Her Majesty's Inspectorate Probation (HMIP) since 2003 CSSIW has worked with HMIP providing

the Care Social Services in Wales's expertise and a lead inspector for the majority of the inspections in Wales.

- CSSIW endorses the HMIP document "Joint Inspection Findings of Youth Offending Teams in Wales 2003-2008".
- HMI Probation new Inspection of Youth Offending Programme started in April 2009 and CSSIW will continue to contribute to both the Core Case Inspection (CCI) programme and a thematic programme in Wales.
- HMI Prisons undertakes the inspections of Parc Youth Offending Institution (YOI) Bridgend which has provision for Young people.

Hillside Secure Children's Centre

Hillside Secure Children's Centre is the only secure children's facility in Wales having opened in 1996. It forms part of the overall provision of the secure estate provided in England and Wales and in addition to the fourteen beds contracted by the Youth Justice Board through a service level agreement, Hillside provides four welfare beds under Section 25 of the Children Act 1989. Young people are placed in Hillside through the Courts, due to their offending behaviour and/or because they pose a significant risk to themselves or others in the community.

Further information in respect of regulatory inspection can be found at appendix 1.

Findings from annual inspection Hillside Secure Children's Centre

CSSIW annual inspection of Hillside was undertaken in April 2009 and is at appendix 2. There were no outstanding requirements identified from the previous report and no new requirements identified from this inspection.

Responses to the issues raised in the terms of reference for the inquiry

CSSIW has submitted responses to those questions for which we have evidence. These comments should be considered along side the findings in the Children and Young People Subject to Custodial Sentences chapter of the HMI probations report "*Joint Inspection Findings of Youth Offending Teams in Wales 2003-2008*".

What action should the Welsh Assembly Government take to improve the experience of Welsh children in secure estate?

The principals underlying the Children Act should apply to any placement and children in secure settings must be able to access a similar range of rights and entitlements as those children in other settings or in the community.

Particular issues :

- Placement location is a significant issue as being placed a considerable distance from home can reduce the young persons contact with family, result in language difficulties and impact on their cultural identity. It can therefore add to the young person's isolation and vulnerability. Distance potentially also impacts on the effectiveness of care planning and resettlement.

- Children and young people need access to appropriate mental health and substance misuse services whilst they are in the secure unit but also as part of their plan for returning to the community. It is important that there is continuity in planning and provision of services.
- Planning for children leaving secure units needs to be effective and an appropriate support package developed which includes a range of relevant services including support, placement and housing options. Inspections indicate that greater emphasis is needed in preparing the young person for returning to their community.
- The young people in the youth justice service are very vulnerable and robust safeguarding systems are needed to promote the young persons welfare.

How effectively does the All Wales Youth Offending Strategy address issues to do with the secure estate?

CSSIW welcomes the approach as set out in the *All Wales Youth Offending Strategy*. The strategy seeks to provide a more holistic approach in relation to youth justice in Wales's which emphasises preventative and multi agency working.

What particular problems are there in implementation and the delivery of support services for children and young people in the secure estate, including mental health provision, support for education and resettlement services?

CSSIW Inspections have found the following services available within the Hillside Secure Centre:

- Mental health support services - the unit has a Psychiatrist and Psychologist attached to the centre.
- The Barnardo's TAITH -working with perpetrators of sexual abuse
- WGCADA (Drug and Alcohol project)
- Education –Estyn inspectors have not identified any major shortcomings in relation to Education. At the time of the last inspection workshops were due to be built which would allow a more flexible, skills orientated approach. As the YJB contract is a British contract there have been some issues identified in the past in relation to compliance with the Welsh curriculum.
- Resettlement, Hillside provides no direct follow up with the young people when they leave the unit. Some indirect contact in the short term could help to strengthen the young persons support network. However this could only be considered as part of an agreed multi agency discharge plan.
- Further opportunities for the development of independence skills should be considered as recommended in the 2008 – 2009 annual inspection report.
- The issue in relation to all of the above would be the importance of ensuring assessment of need and the continuity of service provision while the young person is within the secure estate but also as part of the multi agency plan for a young person's return to the community. The HMI Probation report " Joint Inspection Findings of Youth Offending Teams in Wales 2003-2008" concluded that children and young people in custody were well supported by visits from youth offending team staff, even though they were often a distance away and in England. However, on release, partner agencies such as health, education and social services did not always provide the services needed"

To what extent is the Welsh Assembly Government’s “rights based agenda”, in its support to children and young people, delivered to Welsh children in the secure estate?

CSSIW Inspections of Hillside Secure Children's Centre indicates that a Welsh Assembly Government’s “rights based agenda” is promoted by the unit.

Examples of this included :

- Religious and cultural needs are appropriately respected and met.
- Issues of bullying are taken seriously and responded to by staff
- Weekly young peoples meetings are held to promote the voice of the child
- Within the boundaries of the centres remit young people are encouraged to make choices.
- Personal allowances provided
- Young persons right to confidentiality and respect upheld
- Advocacy service provided by NSPCC

Do specific groups of children and young people need additional support e.g. BME groups, young people with a disability or learning impairment, Welsh speakers, young carers, and girls and young women?

CSSIW inspection of the Hillside Secure Children's Centre identified that :

- Relevant information is provided to the unit regarding the young person prior to admission for consideration by the internal admissions panel.
- Each young person in the centre had a care plan and was allocated 2 key workers
- All young people had a medical assessment upon admission to the centre
- A planning meeting was generally held within 5 days of admission on every child
- Following the initial planning meeting each young person would be referred to the psychologist if this was considered necessary to meet their needs
- One of the bedrooms was designed to accommodate a young person with a physical disability
- Staff were generally considered to have a good awareness of the diverse needs of the young people in the centre and there is a good gender balance within the staff group to support the needs of the young people
- The majority of staff are white Welsh with few Welsh speakers

What further action is needed to reduce use of custody and to promote alternative measures to detention for children in conflict with the law?

Services for vulnerable children need to be more closely aligned across all organisations at national, regional and local levels to enable more effective working together and to safeguard and promote the welfare of the child or young person.

Appendix 1

Hillside falls under the category of a children's home as defined in Section 1 of the Care Standards Act 2000. The centre is currently registered to provide care for 18 young people of either gender between the ages of 12 and 17 years. There is a requirement that *"A child under the age of 13 shall not be placed in secure accommodation in a community home without the prior approval of the secretary of state to the placement of that child"*. Under the Government of Wales Act 1998 and the Transfer of Functions Order 1999, responsibility for giving approval for such placements in Wales rests with the Welsh Assembly Government. CSSIW provides professional advice in relation to these applications.

Hillside is managed by Neath Port Talbot County Borough Council and they are required under the Children's Homes (Wales) regulations 2002 (regulation 32) to undertake and report on monthly visits to the unit. These reports are provided to the council's Children's Overview and Scrutiny Committee. The manager of the home must also provide reports to the committee on the operation of the home. The Neath Port Talbot Local Safeguarding Children Board has safeguarding roles and responsibilities in relation to the unit.

Background

In 2003 Hillside was registered by the then CSIW, now CSSIW. It was registered under the category of a Children's Home providing accommodation for the purpose of restricting liberty.

Since 2003, Hillside has been inspected annually against the Children's Homes (Wales) Regulations 2002 and the Children (Secure Accommodation) Regulations 1991. Since July 2007 they have also been subject to the Children's Homes (Wales) (Miscellaneous Amendments) Regulations 2007.

Until 2006 Hillside was also licensed as a secure centre by the Social Services Inspectorate Wales (SSIW) and was subject to a triennial inspection by the SSIW. In 2003 there was a joint inspection by the SSIW and CSIW and in 2006 led by CSIW. After this date the centre was no longer required to be licensed but instead registered by the Care and Social Services Inspectorate Wales (CSSIW).

CSSIW regularly invites other inspectorates such as Estyn and the Estates inspectorate to join the inspection team. In the last inspection the pharmacy inspectorate were included in response to issues identified around medicine management.

CSSIW standards for regulatory inspection

The centre is inspected against the above mentioned regulations but inspections also take account of the National Minimum Standards for Children's Homes issued by the Welsh Assembly Government under Section 23 of the Care Standards Act 2000. The standards are grouped under a series of key topics:-

1. Choice of Service
2. Planning for Individual Needs and Preferences
3. Quality of Life
4. Quality of Care and Treatment
5. Staffing

6. Conduct and Management of the Service
7. Concerns, Complaints and Protection
8. The Physical Environment
9. Specialist Provisions

In October 2006 the Welsh Assembly Government issued Additional Standards for Children's Homes providing Secure Accommodation under the Children (Secure Accommodation) Regulations 1991. These give criteria and outcome indicators under the main topic headings of:-

1. Statement of Purpose
2. Resources Available to the Secure Establishment
3. Improving Life Chances
4. Quality Performance
5. Physical Environment

Regulatory Inspection

Inspection is the means by which CSSIW determines that continued registration is justified and it also ensures compliance with the:

- Care Standards Act 2000 and associated regulations, whilst taking into account the National Minimum Standards for Children's Homes.
- The home's own statement of purpose.

The primary focus of the CSSIW inspection report is therefore to comment on the quality of life and care experienced by service users.

CSSIW inspectors are authorised to enter and inspect children's homes at any time. At each inspection episode there are visit/s to the service during which CSSIW may adopt a range of methods in its attempt to capture service users' and their relatives'/representatives' experiences.

CSSIW Inspection methodology includes the use of questionnaires to young people, staff and families, service user focus groups, interviews with care staff, domestic staff, administrative staff, management and support staff including the health care staff. There is also an inspection of files and records, observation of care practice and review meetings and inspection of the building.

These methods are informed by the range of information provided in advance to the inspectorate by the establishment.

Alongside this Inspectors may also undertake visits throughout the year to investigate complaints and to respond to any changes in the service.

The resulting CSSIW inspection report reflects the findings of the inspector at a specific period in time. The registered person/s remains responsible for ensuring that the home operates in a way which complies with the service specific regulations.

The findings in respect of the regulations, which CSSIW believes to be crucial in bringing about change in the particular service, are identified in a requirement section of the report. Where key requirements have been identified, the provider is required under Regulation

33B (Compliance Notification) to advise, in writing, the appropriate regional office of the completion of any action required by CSSIW.

As well as listing the key requirements from the current inspection, the requirements made by CSSIW in earlier inspections, which have been met and those which remain outstanding are also included in the updated report.

The Care and Social Services Inspectorate Wales is required to make reports on registered facilities available to the public. In respect of the Hillside inspection reports these reports are produced annually and copies are made available to the centre, to Neath Port Talbot County Borough Council and on request to the public and any placing authority.

Management of complaints /safeguarding role

The regulated setting has responsibility for having a clear, effective and fair complaints procedure in place which promotes local resolution between the parties in a swift and satisfactory manner, wherever possible. CSSIW may be involved in the investigation of a complaint and where this is the case CSSIW will again make a summary of the complaint publicly available.

A fundamental aspect of CSSIW's role is to ensure that regulated services safeguard service users and promote their welfare. CSSIW recognises that children who use regulated services are vulnerable to other people's actions and could be subject to abuse or neglect.

CSSIW is placed under a duty in section 8(6) of the Care Standards Act 2000 to have particular regard to the need to safeguard and promote the rights and welfare of children in the exercise of their functions under the Act. Anything that suggests that this may not be the case, e.g. a child protection concern about a child using a regulated service, will require CSSIW to consider whether the regulatory framework is being complied with.

CSSIW has clear roles and responsibilities in the event of any alleged or suspected abuse or neglect in a regulated service. These are set out in Welsh Assembly Government guidance. *Safeguarding Children: Working Together under the Children Act 2004*"

The local authority and the police have the lead role in determining whether significant harm has occurred, in line with statutory guidance and local procedures, but CSSIW has an essential part to play in the multi-agency approach to the protection of vulnerable children within regulated services and settings.

The local authority must engage with CSSIW and other agencies, as appropriate, to determine a strategy for enquiries or investigation that takes account of the statutory duties and responsibilities of all agencies. Each agency will keep the other informed of developments that may have implications for the others' responsibilities."

CSSIW will be party to enquiries / investigations in settings / services it regulates taking into consideration both the child protection and regulatory issues.

The unique role and responsibility of CSSIW is to consider whether the registered / responsible person/s have complied with statutory and regulatory requirements to safeguard and promote the welfare and wellbeing of vulnerable children. CSSIW will need to consider the continued "fitness" of the registered /responsible person/s and whether

they need to take any action, including considering whether the service can continue to operate.

Appendix 2

Care and Social Services Inspectorate Wales

Care Standards Act 2000

**Inspection report
Children's Residential Care**

Hillside Secure Centre

Burnside

Date of Publication – 23 April 2009-10-12

Summary of Findings

Hillside Secure Centre is registered under the category of a Children's Home providing accommodation for the purpose of restricting liberty. In the inspection of the centre the Children's Homes (Wales) Regulations 2002 and the Children (Secure Accommodation) Regulations 1991 are applied along with the National Minimum Standards for Children's Homes and the additional standards for Children's Homes providing secure accommodation.

Hillside Secure Children's Centre is a secure children's facility managed by Neath Port Talbot County Borough Council and at the time of inspection was the only one of its type in Wales having opened in 1996. It forms part of the overall provision of the secure estate provided in England and Wales and in addition to the fourteen beds contracted by the Youth Justice Board through a service level agreement, Hillside provides four welfare beds under Section 25 of the Children Act 1989. Young people are placed in Hillside through the Courts, due to their offending behaviour and/or because they pose a significant risk to themselves or others in the community. The young people for whom the accommodation was provided were between the ages of 12 and 17 years. Approval was required from the National Assembly for Wales for any young people under 13 years of age being placed under Section 25 of the Children Act 1989.

The inspection of Hillside took place during one week and was in line with the Care and Social Services Inspectorate Wales' (CSSIW) policy, based on a proportionate approach. The inspection included announced and unannounced visits to the home. These visits were used for discussion with the staff members and the management team and some discussion and observation of the young people. Questionnaires were also provided prior to the inspection visit. Additionally, during the visits there was the inspection of documents used for recording in the home including case tracking and also observation of the operation of the home. These visits along with other contact with the home in the year through visits, meetings and electronic messages informed the findings of this report.

As part of the main inspection, medicines management was inspected by the CSSIW pharmacist inspector, focussing on administration and practice issues. Recommendations were made to support good practice, and further information is included in the body of this report.

Section 1 choice of home

Hillside Secure Children's Centre is a secure children's facility managed by Neath Port Talbot County Borough Council and at the time of inspection was the only one of its type in Wales having opened in 1996. It forms part of the overall provision of the secure estate provided in England and Wales and in addition to the fourteen beds contracted by the Youth Justice Board through a service level agreement, Hillside provides four welfare beds under Section 25 of the Children Act 1989. Young people are placed in Hillside through the Courts, due to their offending behaviour and/or because they pose a significant risk to themselves or others in the community. The young people for whom the accommodation was provided were between the ages of 12 and 17 years. Approval was required from the National Assembly for Wales for any young people under 13 years of age being placed under Section 25 of the Children Act 1989.

The Statement of Purpose was last amended in September 2008. It was a comprehensive document containing the requirement of Schedule 1 Regulation 4 (1) of the Children's Homes (Wales) Regulations 2002. The Statement of Purpose was signed by the Responsible Individual as required in the last inspection report. An extensive range of policies supported the Statement of Purpose which were dated to indicate the version. A number of policies had been reviewed during the previous year. Copies of the policies were available in the unit offices and there was evidence that staff were informed by memorandum when changes were made. It was obviously a challenge to ensure that all staff members kept themselves updated on all policies especially the core policies for example child protection which was due to change and control and restraint although all staff did receive a handbook on restraint training which will be discussed later in the report. Consideration might be given to a staff handbook containing key policy and procedure documents.

The children's guide which was amended in September 2008 was provided in a document holder which included information from the NSPCC Advocacy project, the Children's Commissioner for Wales and the Children's Complaints officer for Neath Port Talbot County Borough Council. The introduction clearly advises young people that Hillside is a children's home with locked windows and doors and is not a punishment centre or prison. Apart from amendments the children's guide was mainly developed by staff and young people residing in the centre in 2001. It contains comments from one of the young people through the document and all comments were informative. A minor amendment required at the time of inspection was to reflect the changes in the education staff.

The centre provided a 12 page guide for Local Authorities covering the Mission Statement for the centre, child care principles employed, a general introduction to the centre, explanation of what a secure children's home is, planning for children, care planning meetings, care planning reviews, service details covering education, health, emotional and behavioural development, social and family relationships, self identity, programme of intervention, leisure and effective outcomes and information about the location of the centre. The guide ends with a quotation: "Hillside should be an informed positive placement for children and young people as the results speak for themselves."

There was a visitor's guide provided for any parent or professional who had a child placed in the centre and again this provided more information about the operation of the centre. This included the arrangements for visiting, restricted items, telephone contact, clothing pocket monies and leisure in addition to what to do if a complaint needs to be made. The guide contains photographs and plans of the layout of the units. The guide also included information about what to do if an individual wished to complain.

The admission DVD had been produced a couple of years previously and it had been stated to be a very useful tool for the young people to view on admission. None of the young people involved could be identified and several staff members were involved in the production. The film had been split into several areas and was an appropriate length.

The Youth Justice Board managed the placements at Hillside Secure Centre contacting them to inform them of young people requiring placements. Hillside then received information about the individual which was passed to the Duty Manager. A judgement at the internal admissions panel was then made about whether or not they were able to offer a placement. The admissions panel checklist was completed and it was a requirement that all relevant documentation to the decision making was received before the panel was convened. It was clear that the Centre would not fill a vacancy if the young person was not deemed appropriate. Hillside was also in close contact with the local Welsh Authorities to inform them of any placement vacancies that they may have in view of any young person being placed a distance from home wishing to transfer to Hillside. The centre had a referral form which requested information about the young person, their legal status, brief history, reason for referral, any alternatives considered, care plan, contact arrangements, educational and medical history, any offences and a risk assessment.

Upon admission the young person was admitted to the unit where a vacancy was available. On occasion the young people moved from one unit to another and this was frequently following an introduction period to assess suitability. If the move was not successful it would be reviewed. In most instances a move was from Tawe or Afan to Nedd for one of the boys who was due to spend a longer period in the Centre as Nedd dealt mainly with those on a longer term placement.

All new admissions to the home were made via the admissions suite and the young people were taken directly into this suite via the secure vehicle entry at the side of the building. In the vehicle dock two members of staff met the young people and recognising that this was a very stressful time attempted to put the young person at ease. It was noted that many young people arrived at the Centre tired, hungry and quite naturally in a highly emotionally charged state. The staff members completed an admissions form and then a search process was completed to ensure that no restricted items were taken to the units. The young people had the opportunity to shower and their clothing and possessions were searched. If it was considered necessary to complete a body search this would be carried out by medical staff only. The staff members also organised a urine test in order to establish any drug use in order to ensure immediate referral to the centre's general practitioner in case of medication needing to be prescribed. The centre had a policy document and form produced in May 2005 in respect of urine testing for controlled drugs. The young people were advised that the testing was not for the purpose of reporting any evidence of substance misuse but purely a precaution in case medication was required. The young people were in a position to refuse this test if they chose and for

younger children parental consent was established. Staff members were sensitive to the admissions process and a young person might spend the first night in the bedroom of the admission suite or if their arrival was at a reasonable hour of the day they might transfer to the unit allocated.

Discussion with the assistant manager indicated that the centre would see a further development upon admission to be for the young people to receive an ECG test. This had been discussed following the admission of one young person who had not been diagnosed with a heart defect which would have required different instructions in relation to restraint.

The young people brought some possessions with them, however, this varied from one young person to another. There were restrictions as to what items any young person could have and those not allowed would be placed in safe storage for the young person until they left the centre. Initially upon admission the young people were subject to a risk assessment of their vulnerability and the number of possessions they were allowed was considered accordingly.

Planning meetings were due to be held within five days of admission to the centre attended by the young person, their family, the young person's social worker or YOT worker and Hillside staff. Inspection of the records confirmed that this practice generally worked well, although a couple had been delayed due to the availability of the chair. Further dates for meetings for the next three months were also agreed at this time.

The NSPCC had taken over the advocacy role in the Centre in April 2006, there were posters on each unit to give information about advocacy and leaflets in the information pack. Discussion with staff and young people confirmed that the Advocacy project were regular visitors and could be approached for discussion spending regular times on the units. It was noted that an advocate had also attended a review meeting in support of a young person.

Requirements made since the last inspection report which have been met:

Action required	When completed	Regulation number

Requirements which remain outstanding:

Action required (previous outstanding requirements)	Original timescale for completion	Regulation number

New requirements from this inspection:

Action required	Timescale for completion	Regulation number

Good practice recommendations:	NMS or other source
Consideration could be given to a staff handbook containing all policies and procedures	

Section 2 – Planning individual needs and preferences

A planning meeting, normally held within five days of admission was chaired by the Assistant Manager for Professional Services or another Manager at Hillside and at this meeting the placement aims and objectives were agreed, identifying the actions required to achieve them. Between the date of admission and the first planning meeting daily recordings were not made, instead recordings were made on form T1A/V which had been amended in the past year. This covered education, health, emotional and behavioural development, social and family relationships, contact records, identity and social presentation, offending behaviour, leisure activities, child protection issues including self-harm, vulnerability risk and behaviour management, physical needs and the views of the young person. Summaries were made from these recordings on the morning of the planning meeting. Additionally, the young people completed a form with their key-worker to prepare themselves with comments for their meetings. It was clear in the policy of the centre that the YOT or Social Worker was responsible for inviting all relevant agencies to the review meeting.

All care plans were formally reviewed and the meetings attended by the relevant individuals after one month of admission and thereafter at a period not exceeding three months. Additionally on a monthly basis interim progress review meetings took place between the plan co-ordinator, key-worker, young person and social worker or YOT worker. ASSETT plans, for young people placed through the YJB were reviewed monthly. The frequency of these meetings ensured that aims and objectives were constantly monitored as to their appropriateness and drift was avoided. The appointed plan co-ordinator for the young person was responsible for completing a document prior to review which outlined progress and updated upon key working and professional intervention. Discharge planning began at the start of the placement in order to try and achieve a smooth transition from Hillside back into the community. Influencing continuity of service provision was a continuing challenge for Hillside staff.

In order to ensure young people views were listened to and their views taken into account, young people's meetings were held on a weekly basis on each unit. The meetings were held between 9 a.m. and 9.45 a.m. when the teaching staff had a staff meeting. There were records of these meetings maintained on each unit which identified the young people present, the staff members present, the agenda, issues discussed and any decisions made. Some of the issues could not be resolved in the meetings and required referral to the management team and the action statement reflected this and the feedback received for the next meeting. During the centre briefing on a Monday morning there was feed back from each unit about the areas of discussion held at the young people's meetings. In order to improve communication between the young people and senior managers, a meeting was held with a representative of each unit and the Assistant Manager Operations along with any significant person depending upon the agenda items. The kitchen staff had attended some of these meetings and commented positively upon their impact. Recordings and discussion indicated that the young people considered this an important stage in their voice being heard. The opportunity to make everyday choices about living was restricted by the nature of the Centre, however, within the boundaries set the young people were observed to be encouraged to make as many choices as they could.

It was acknowledged that key working was an important feature of the work undertaken with young people. The plan was that work would follow agreed programmes focussing on key areas such as self esteem/confidence, anger management and consequences of offending/ victim awareness. These sessions were planned to compliment the services provided by external services such as TAITH (Barnardos project) and WGCADA (Drug and Alcohol project). Information on these services were provided to the young people in the guide they received upon admission.

Inspection of records and discussion with individuals indicated that young people's religious needs were considered. If appropriate contacts in the local community were used to provide advice and a direct contact for young people. At the time of inspection none of the young people required this support. The families of the young people were encouraged to visit the home; however, the frequency varied considerably depending upon the individuals concerned. A visitor's suite was available for families with distances to travel to stay and it was observed that staff were organising this for one mother at the time of inspection.

Each young person had an individual case record which contained 10 sections containing all documentation, risk assessments, recordings, summaries, counselling sessions; incident forms and bedroom isolation and monitoring forms; mobility and unauthorised absence sheets; support service reports and appointments; medical consent forms and profiles and any treatment or accident forms; induction forms, clothing lists, personal possessions records and personal allowance forms; Court Orders and legal correspondence and finally any confidential information. Inspection of the files of the young people resident at the time of inspection confirmed that they contained the information required of Schedule 3 of the Children's Home's (Wales) Regulations 2002. The staff members had been issued with guidelines as to the appropriate use of language in recordings and the requirement to identify fact and opinion. It was noted that the quality of recordings had improved over a number of years and the files were kept in better order with regular internal monitoring.

Subject to certain criteria and risk assessments mobility, a term used for time out of the centre would be facilitated by Hillside to prepare a young person for their return to the community. The opportunity for mobility depended upon the placement plan and could include participation in activities such as the Duke of Edinburgh Award Scheme or work experience. A young person subject of a criminal conviction might not be able to be considered for mobility. The staff completed careful assessment of any mobility before permission was granted. Within the centre there were some limited opportunities to prepare for independence in cooking and laundry. It was recommended that further opportunities for preparation for independence be explored for some of the young people.

The staff members were advised of the confidentiality policy during their induction to the centre and staff members were very aware of the need to adhere to this. It was noted during the inspection that the staff did not disclose to the other young people any of the offences the young people had committed or were alleged to have committed. The staff members were also careful to ensure that when recording or reading files that the young people were not looking through the office window when they could easily read the notes. There were a number of appropriate policies in place to ensure safety. These included a policy in respect of the bedroom en-suite facilities, which were locked after use.

The centre had a search policy and procedure, which was explained to the young people upon admission and they were shown the list of restricted items. At this stage it was hoped that the young people would hand over any restricted items which would be kept in safekeeping. Under no circumstances were the staff members to use physical force to search the young people. The young people were encouraged to make use of the shower in the admissions suite and when using it their clothing would be checked if there was any suspicion that any dangerous substances or weapons were being brought into the centre. The staff had a metal detector to use if they believed any restricted items were being hidden on the person. The Centre would call upon the doctor if a physical inspection of a young person was required. The centre had individual sheets for the recording of any searches of young people or their possessions.

Security checks were carried out twice daily covering: bedrooms, living area, kitchen, corridors, and the laundry room, quiet room and the office. The garden area was also inspected before the young people were able to make use of this area and the recent addition of a clothes line and pegs was included in this search. The recording of these checks required the detailing of any urgent domestic tasks necessary, any security or maintenance issues requiring attention and whether or not a building defects form had been completed. To ensure appropriate boundaries within the units there were a number of policies in place.

Requirements made since the last inspection report which have been met:

Action required	When completed	Regulation number

Requirements which remain outstanding:

Action required (previous outstanding requirements)	Original timescale for completion	Regulation number

New requirements from this inspection:

Action required	Timescale for completion	Regulation number

Good practice recommendations:	NMS or other source
Further opportunities for the development of independence skills should be considered.	

Section 3 Quality of Life

In order to ensure the young people were well dressed and could exercise choice and individuality the Centre had a policy to cover the clothing and personal requisites of the young people. This stated that each young person was entitled to a minimum of four sets of clothing and lists were available for young women or young men as guidelines. One condition was that no item of clothing could contain a cord or drawstring. The young people were not allowed to have clothing with any words or slogans that might offend others. The young people had a maroon t-shirt to wear when attending education. The clothing policy made it clear what items were required and what families were able to purchase for the young people. Any jewellery was also kept safely to be returned to the young person upon discharge from the home. Staff were observed to contact a previous placement to organise the safe return of items left behind at the time of transfer from another centre.

In the units the young people were not allowed to wear outdoor shoes and they were placed in the cupboard to be worn to education, the garden, activities or meetings. The centre ensured that all young people had slippers to wear. The young people would be provided with clothing if they were in need with finances available in the administration unit. This clothing would then be the property of the young person. The centre did hold some clothing, which could be used in an emergency overnight if a young person were admitted without any suitable clothing. The centre also ensured that the young people had suitable clothing to attend Court. If clothing was required the staff would discuss needs and preferences with the young people. The staff member would then purchase clothing on behalf of the young person. Upon discharge from the centre all young people were supplied with a holdall if they had no other means to carry their possessions, clearly black refuge bags were not acceptable.

The use of aerosols, razors and other sharp items were restricted and the young people were provided with a welcome pack containing toiletries upon admission. Any restricted items were placed in safe keeping and if they were toiletries they were kept in the office cupboards. Staff members were observed to hand the young people toiletries for use at the office door. These were replaced as and when necessary during their stay in the home and it was noted that the staff members ensured a range of products to make certain that the young people with any allergies or special requirements had their needs catered for.

Personal allowances were provided for the young people weekly at the rate agreed by Neath Port Talbot County Borough Council. The amount varied according to age and any sanctions could allow a maximum of 2/3rds of this amount being withheld in order to pay for any damages or repairs. A record was maintained of the money held in savings for the young people. Care staff did shopping for the young people at weekends, each resident was asked to make a list of their individual requirements on a Friday evening. The shift leader was responsible for checking that the young person had sufficient funds and money was provided from petty cash. Following the purchase of the item/s the young person signed authorisation for the exact amount and a receipt was attached.

The centre worked hard to promote contact and contact plans were discussed at the time

of admission and recorded on the individual contact card. Until the first planning meeting contact with everybody except the social worker /YOT worker would be supervised. After the first review meeting contact would depend upon the agreed plan and for some young people this remained supervised. There was evidence on one file of information received from a Youth Offending Team of relatives suitable for contact. It was also noted that one young person was given verbal agreement from the YOT worker to be able to have contact from certain friends before the planning meeting as it was going to be delayed several days.

Staff were aware of the need to supervise contact but at the same time try to be sensitive to the limited time people have together. The contact visits had to be planned and booked 24 hours in advance as the rooms had to be booked and during term time the visits were held between 4 and 5 p.m., 5 and 6 p.m. and 7 and 8 p.m. During the weekends and school holidays visits were between 11a.m. and 1p.m., 2.30 and 3.30 p.m., 4 and 5 p.m., 6 and 7 p.m., and 7 and 8 p.m. Visitors were not allowed access to the centre unless they had booked a visit and a maximum of four people were allowed at any one time excluding small children. The main visitor's room provided a pleasant family environment; it had been decorated by some of the young people and contained soft furnishings and a supply of games for young children.

Telephone calls from family and friends were made between 4p.m. and 9 p.m. on school days. On other days the only restrictions could be around meal times and activities. The young people were observed to book their telephone times and when the time was due the staff would dial the number and transfer the call to a private location. Difficulties were observed to arise on occasions when a young person was due a call but another young person had received a call and some negotiation was required at these times which staff handled sensitively. A telephone book was in use on each unit to record the time and the number dialled in addition to recording this information on the individual young person's file.

The centre had a policy and procedure on incoming and outgoing mail. All incoming letters or parcels were opened by the young people in the presence of staff to ensure that there were no illicit items reaching the units. The staff would not read any letter unless asked to do so by the young people. All incoming mail was handed to the unit staff in the centre briefing for them to issue to the young people and it was recorded under contact. Staff members were observed to hand out mail to young people at the end of the school day. If there was any suspicion of restricted items being sent to a young person or that the letter was from a person with restricted access the Duty Manager was informed. If the young people wanted to send out any letters they were provided with writing materials and the centre incurred the cost of sending mail to family or professionals. The young people were charged for the cost of postage to friends. Staff were alert to one young person suggesting a letter be signed by a different name in order to receive it and they talked through with the young person the requirement to read the content if they suspected this attempt at deceit.

The young people attended education daily in the centre and they were placed in one of four different groups named by colour. If the education staff believed that a change of group was required they would make that decision at 4 p.m. during the teachers briefing and the Duty manager would inform the unit staff in order that the young person could be told of the changes and the reason. Alternatively, this would be discussed at the 8.30

a.m. teachers briefing and the unit would be informed by 8.45 a.m. when staff could decide whether to inform the young person immediately or keep them off the first lesson and advise them then. As far as possible the young people were grouped according to ability, however, there were occasions when clashes of personality required movement to a less able group. Inspection of the files indicated that the young people had often lacked education prior to their placement at Hillside either through exclusion or opting not to attend.

The school day commenced at 9 a.m. with a 30 minute break at 11.15 a.m. and a one hour break at 1.15 and school finished at 3.45 p.m. There would be no more than five young people in each class, which would have a teacher and a member of care staff in attendance. It was noted that there was less reluctance on the part of care staff to carry out this role than in previous years. In the event of a group being assessed as requiring extra support a second teacher would be allocated. There were six teaching staff each one responsible for two subjects on the curriculum. The school had an art room, woodworking room, four classrooms and a kitchen in addition to the sports hall and Astroturf area. The school year was organised in accordance with the requirement of the Youth Justice Board that the young people did not have more than two weeks off school at any time. This was organised into seven two-week breaks during the calendar year. During an unannounced inspection to the centre a school assembly was observed with the pupil of the week being awarded. The pupils, teaching staff and care staff then split into groups to complete a task in competition with each other. It was also noted during the inspection that one young person had been assessed as requiring one to one education support which had been organised.

Teaching staff were observed to spend time with any new admissions on the unit before they entered education in order to introduce themselves and also to complete an initial literacy and numeracy assessment.

In order to encourage positive behaviour and recognise achievements made by the young people, the school used a reward system. This recognised consistent effort and improvement and rewarded the young people through a points system, which led to a prize being awarded weekly. The points were reviewed on a Tuesday for the previous week and certificates presented in the centre core in the morning to the best pupil of the week and the pupil with the best improvement. The Youth Justice Board required feedback on the percentage attendance of all of the young people. The points allocated to the young people were converted into money and the young people would be able to purchase items through their care plan co-ordinator on a Saturday morning. The young people usually purchased compact discs and only in exceptional circumstances would they save this money to purchase a larger item. The points were recorded on the daily recording sheets for the young people. Estyn had completed an inspection in 2006 and the centre had been attending to the recommendations made. There had also been a change with the assistant manager for education leaving and being replaced by the promotion of one of the teachers. There were changes being made at the time of inspection to develop vocational programmes and also discussion about parenting classes. Further review of the education provision will be made at the next inspection.

There were a number of sports activities available at Hillside with the sports hall and Astroturf area offering the opportunity for football, netball, volleyball, cricket, badminton to name a few. The Astroturf had not been used for a few weeks at the time of inspection

due to the surface being slippery and it was stated that consideration had been given to purchasing specialist trainers for the young people suitable for this surface. Additionally, there were pool tables on the units and a table tennis table. The units each had televisions, with DVD players and a library of films, which could be accessed. There were Play Stations or an X-box or Wii on the units and staff ensured that all activities were age appropriate. A discussion about this was observed during a staff handover with concern expressed about the suitability of some games even though they could be considered age appropriate. The conference room had also been set up as a cinema where, once a week, the young people from all units could watch films. There were a number of board games available although the use of these resources varied depending upon the young people resident. There was a daily allowance granted for activities which enabled the purchase of some materials, additionally some art and craft materials could be purchased through the education budget. On one day of inspection there was a training day for teachers with no education for the young people. It was noted that the staff ensured that activities were suitable for all to participate as one young person was not able to participate in any physical activities.

In order to celebrate festivals and holidays the units would compete in decorating their units and the winning unit would receive a cash prize, which the young people could choose how to spend. In the Summer months the units had paddling pools in the gardens which the young people enjoyed and also barbecue facilities. With only one young woman at the start of the week the activities were biased towards the males but a further admission in the week redressed this difficulty. It was recognised that the balance needs to be drawn between structured activities and the requirement for the young people to have free time to use responsibly. Sessional workers were available to provide the young people with a number of experiences including welding, electrical work, painting for which the individuals often supplied their own equipment. Inspection of the minutes of the young people's meetings confirmed that they discussed activities and any resources they might require. The Centre had a level 6 club which was available to all of the young people on a level 6 risk assessment for their bedroom. It allowed the young people to use the key-worker room on the unit for additional rewards for their continued well managed behaviour. There was a review of the level 6 rewards at the time of inspection. The young people were also engaged by the staff to consider the implication of their actions and to avoid losing any of their rewards.

One of the units had introduced themed months and at the time of inspection this was black culture. The young people were proud of the collage they were developing on music on one wall and additionally on other walls they had famous black sportsmen and women and politicians.

Risk assessments were in place to cover the young people making use of compact discs or DVD's in their own rooms and there had been examples of young people smashing the discs. There was a policy, which required all discs to be originals, and copies were not permitted in the Centre. The Centre had two vehicles available for the staff to book for mobility which were not marked and would not be viewed as special vehicles.

Requirements made since the last inspection report which have been met:

Action required	When completed	Regulation number

Requirements which remain outstanding:

Action required (previous outstanding requirements)	Original timescale for completion	Regulation number

New requirements from this inspection:

Action required	Timescale for completion	Regulation number

Good practice recommendations:	NMS or other source

Section 3 – Quality of Care and Treatment

Each young person had a care plan and was allocated two key-workers. Following the first planning meeting a young person would be referred to the psychologist if this was considered necessary to meet their needs. The Psychologist considered this process effective for alerting at an early stage a young person who might benefit from her input. The Psychologist was in the centre on a Monday and Tuesday, which allowed for a new assessment every week in addition to the ongoing sessions. Some of the work undertaken had limitations due to the length of stay that some young people had at the centre. At the point of departure from the centre the Psychologist prepared a report on the work with the young person that was sent to the placing agency as the Psychologist was not in a position to refer a young person directly to the community. It was stated previously that most YOT teams now had a Community Psychiatric Nurse attached who was able to support any referrals to the community. The Psychologist had changed in the past year and there was a period of overlap. It was noted that the Psychologist completed a memo to staff following any session giving broad areas of discussion and alerting staff to any key areas to be aware of that might influence behaviour.

The CAMHS support was provided through a psychiatrist contract for one day per week. The Psychiatrist and General Practitioner were working together to ensure that young people had the appropriate medication to support their needs. Whilst they rarely met they communicated by telephone or through the medication communication book. The psychiatrist was also available in the week to give any advice and training identified for the staff members during the one hour shift overlap.

The centre had support from TAITH, a Barnardo's project working with young sexual offenders, with a contract for 734 hours support per year. This included support of three sessions per week of three hours per session direct work with the young people. There were also four groups of eight sessions per year of group work support with the young people supported by the staff at Hillside and two members of TAITH staff providing eight days training per year in addition to attendance at some reviews and support group meetings. A member of the care staff was going to visit family in the community with the TAITH worker the week following inspection as they wanted to engage them in the support process with a young person.

West Glamorgan Council on Alcohol and Drug Abuse (WGCADA) an organisation based in Swansea provided the drug and alcohol support. The organisation promotes for individuals the diagnosis, treatment, prevention and rehabilitation of alcohol / drug (substance abuse). They had a number of very useful booklets available for the young people. After each session working with the young people the WGCADA worker completed a form detailing their session. A copy of this form was taken to the unit and placed on the young person's file. The staff members were also in communication with the general practitioner to discuss individual needs.

External support services were managed by monthly meetings of the support services co-ordinated by the Psychologist, which looked at the range of services provided for individual young people. This meeting was particularly important to co-ordinate services for the young people receiving support from more than one service. Each month the focus

was on one of the three units and the staff members from that unit were invited to attend.

The staff members had clear policies to cover their work with the young people dealing with appropriate physical interventions. The staff members looked at restraint as a last resort looking to diffuse situations whenever possible. There were examples of staff employing these diffusion tactics during the inspection. Inspection of the files confirmed that risk assessments had been carried out on the individual young people in relation to any risk posed to them by restraint. The staff members were observed to communicate clearly with the young people and work in a manner, which did not favour individuals. Clearly, this was a requirement as the young people were very sensitive to the behaviour of the staff. The behaviour management training was provided by Response – Options Ltd., with a number of staff trained to be trainers. This provided theoretical and practical modules with diffusion and the skill to identify possible moments of crisis the first stages. Each member of staff received a handbook containing all of the information provided in the course.

The management team was clearly monitoring the type of sanctions being imposed by the staff teams to ensure that bedroom isolation was not used repeatedly when other options were available. There was an attempt to use the range of sanctions imaginatively in order that the young person could earn back rewards for their room if assessed as appropriate. This prevented the young people feeling that there was no benefit in addressing their behaviour and a positive example was observed during the inspection. All sanctions were recorded, signed and reported at centre briefings. In the period between the last inspection and this visit there had been 952 recorded sanctions which reflected a reduction. The Unit Leaders also discussed any sanctions with the Assistant Manager for Operations during their monthly supervision. For the monthly performance reports the sanction was broken-down by unit and also the type of sanction. The sanctions used were: bedroom isolation, dropped level behaviour which restricted the items in the bedroom, early bed, exclusion from an activity, an extra chore or being asked to write an essay. There were 672 incidents of single isolation in the past year. On these occasions the staff monitor the young people either by sitting outside for constant observation or carry out spot checks every 3 minutes or ten minutes depending upon the risk assessment. These checks are recorded on a form and signed off when the young person returns to the communal area.

All staff members were trained in diffusion, behaviour management and control and restraint as part of their induction to the centre and following this refresher training was available at least annually with some courses run monthly and were of two days' duration. The frequency of restraint had reduced in the home, with 156 recorded restraints since the previous inspection. Of these restraints, 108 had been recorded for young people placed by the YJB and 48 by those in welfare beds which was almost identical to the previous year. Any incidents of restraint were recorded and presented in the monthly performance reports indicating the young people involved, the staff members and the unit. The collation of these figures without identification was submitted to the Children's Overview and Scrutiny Sub-Committee. Following any incident resulting in the injury of a staff member a de-brief was held and a decision made about referral of the matter to the local Police.

The centre operated a bedroom incentive scheme, which ensured a consistent progression of the items, and belongings that a young person could earn. The factors

taken into account in making the assessments were the risk management, general behaviour and progress, which included a commitment to key-working, education and offending behaviour, programme. The scheme was under some review at the time of inspection but continued to include 6 levels with level 1 the lowest with the greatest risk assessed and no belongings permitted. New arrivals would generally be placed on level 3 unless a special risk was identified and level 6 would allow personalisation of the bedroom and the use of a television and three other significant items. Additionally level 6 attracted additional power provision, access to the aforementioned level 6 club and a mentoring role for new arrivals. The levels were usually reviewed weekly; however, in response to a crisis situation the Duty Manager could authorise immediate removal of items from bedrooms. "Power" was a key issue for the young people in the Centre as it was the provision of electricity to their bedrooms in order to make use of any electrical items.

The main meals were prepared in the centre kitchen by the catering staff. They operated a five-week menu rota with three choices of main meal, one of which was vegetarian. The young people ordered their meals a week ahead on a Sunday evening although there was some room for negotiation for changes. The Food Standards Agency had produced a training package in 2002 entitled: "Eating well for looked after children and young people". The centre used this document to improve the quality of their provision of meals. Twice a week the units sent an order form to the kitchen indicating the supplies required for the unit kitchen. Staff members were also observed to call in the kitchen for additional snack items and cereals for the young people. Feedback from the young people was mixed in their assessment of the meals provided both in terms of quality and choice but it was mainly positive. It was acknowledged that some young people had very poor diets and would only eat certain meals and it would require time to change their eating habits.

Meals were transported from the kitchen to the units in hot trolleys and transferred to the unit kitchen. The young people went to the hatch in turn to collect their meal and the staff also had their meals at this time sitting with the young people. All cutlery was counted in and out and the young people were not allowed to leave the tables if any item was missing. The young people were observed to be provided with choices and given alternatives if they did not like their original choice.

All of the young people had a medical assessment upon admission to the centre, which was usually commenced by the nurse within 24 hours of a weekday admission and completed by the doctor as observed during the inspection. A form was then completed and left upon the unit. It was recommended that the feedback from the initial assessment be more formal to the duty manager if necessary. The health visitor attended the centre four days a week and the General Practitioner usually on a Wednesday. The care staff contacted the doctor before midday on a Wednesday to arrange any appointments to ensure appropriate consultancy. The nurse dealt with any minor ailment queries and the doctor with any other issues. There was a medical file on the units, which contained medical profiles and clinical notes.

As part of to the main inspection, the management of medicines was inspected by the CSSIW pharmacist inspector. All processes involved in obtaining, storing and administering medicines were discussed. Control and security of medicines was good and well managed. A revision of the recording system was advised to assist in the correct use of prescribed ointments and creams, and medicines prescribed for use 'when

required'. The visiting nurse provided valuable professional guidance and input into the healthcare needs of the young people. To supplement this and the awareness training provided by the supplying pharmacy, it was recommended that further training should be provided to all staff who are authorised to administer medicines. This should improve knowledge and understanding to support safe administration practice. Specific advice was provided on the management and use of medicines for treating minor ailments, on the policy and procedures relating to the handling of medicines, and on action when a young person leaves the centre. More detailed advice on these and other aspects were included in a separate letter sent to the registered manager.

Inspection of the files confirmed that the young people also had their dental needs attended to and young people had also attended an optician in the community for which the Youth Justice Board had granted mobility. The young people also had access to specialist health clinics and the local hospital through mobility.

Only young people aged over sixteen years of age were allowed to smoke and they had a policy to cover the management of this in the unit gardens. Only one young person was allowed to smoke at a time and they were allowed to smoke after breakfast, lunch, tea and supper during the week with an additional mid afternoon cigarette at the weekends.

The individual case files clearly recorded any issues associated with personal hygiene and the young people were encouraged to deal with the issues discreetly by the staff.

Requirements made since the last inspection report which have been met:

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Requirements which remain outstanding:

Action required (previous outstanding requirements)	Original timescale for completion	Regulation number

New requirements from this inspection:

Action required	Timescale for completion	Regulation number

Good practice recommendations:	NMS or other source
<p>The feedback from the initial medical assessment should be formalised</p> <p>All staff authorised to administer medicines should satisfactorily complete a suitable training package, and have their competency assessed to ensure they can do so safely and according to the centre's policies and procedures.</p> <p>Modify the current medicines administration records to include all the medicines prescribed, whether for regular use, short-term use, or use 'when required', ensuring full prescribing directions are included, and review the administration process to ensure the directions are followed.</p> <p>Review the management and use of medicines for treating minor ailments as advised by the pharmacist inspector.</p> <p>Revise the policy and procedures as recommended by the pharmacist inspector.</p> <p>Obtain a copy of 'The Handling of Medicines in Social Care' (Royal Pharmaceutical Society of Great Britain, October 2007) for reference, training and checking of practice and procedures.</p>	<p>Reg 27(4)(a)</p> <p>Reg 21(1) and Reg 21(2)(b)</p>

Section 5 - Staffing

Hillside had a staffing compliment of the equivalent of eighty four full time posts which were distributed as: 59 Care Staff, 6 Education staff, 5 Managers, 5.5 Clerical and 8.5 others.

There was a staff hand over meeting held on every unit at the change of shift. During these meetings the staff members were observed to discuss each of the young people and how they had behaved during the last shift. Any significant events or contact was discussed along with any sanctions, restraints or isolations required. The staff discussed any meetings planned and any appointments, activities or mobility and the arrangements made. There was also discussion about relationships with young people from other units. There was also a handover to the night staff who were a dedicated team working night shifts only. Weekly team meetings were held for the staff members of each shift on each unit on either a Saturday or Sunday morning. Here the staff members reviewed performances and were encouraged to look at what was working well in addition to looking at where improvements could be made.

It was stated that all staff members were subject to a comprehensive selection process prior to appointment followed by a two-week induction before they were able to commence working on the units when they would then shadow for two weeks before being placed on the rota. The responsibility for carrying out checks on previous employment and references was carried by the Personnel Department of Neath Port Talbot County Borough Council. The staff files were not inspected during this inspection process. Staff members were allocated to teams working on one of the units but there were occasions due to shortages or gender balance when a staff member would be asked to work on another unit on a temporary basis. Exit interviews were held with staff on their departure from the centre. Generally there was a settled staff group in the centre with many having worked there for many years. Any movement tended to be from less established staff who did not find they were suitable for the position. Staff were also observed to cover for each other in order to finish a shift early for personal reasons. One member of staff had also been awarded two months unpaid leave to travel. Sickness levels had increased in the last quarter of operation and the management team monitored this closely. There was also some discussion about the appointment of a welfare officer in the future.

One member of staff was responsible for the NVQ assessment and also as a part of this role oversaw some of the other training. Training and Development plans had been produced for all staff members. The process of completing these plans was that the NVQ assessor received plans from the staff member following their meeting with the Assistant Unit Leader. When a training place was allocated to a staff member they were informed by memo through the receptionist who kept a signed list to confirm receipt. A record was kept of all of the core training attended by the staff and also any other training carried out and who attended. Evaluation sheets were also completed after every training session. A copy of the attendance records and non-attendance with reasons was forwarded to the Senior Administrative Officer. At the time of inspection the night staff had engaged in the NVQ level 3 programme which had previously been an area of difficulty. They had also been able to access day shifts in order to satisfy the requirements of the award. The NVQ

assessor had also held workshops for these staff members who could otherwise have been isolated in their attempt to complete the award.

A further development in training in the past year had been the introduction of the mentoring award. Whilst previously this had been an informal arrangement it had become more formalised through this award which required candidates to mentor two other staff members. The award was accredited through the Pontardawe accredited centre and the evidence could also contribute to further awards. This supported the culture of training that the centre was promoting.

The NVQ assessor had also developed new learning portfolio files for the staff. Initially they had been produced for new staff to evidence their induction training for registration with the Care Council for Wales but this had been extended for existing staff also. It was stated that by the end of the six month probation period staff would have had information and training to cover all centre policies and the National Minimum Standards for Children's Homes.

The centre had a training strategy in place and the document clearly indicated the training that would be provided in induction and who would be responsible for the delivery of the various component parts. Additionally, it stated the core training to be provided in the first year of employment and what should be covered in the next two to three years. There were also examples of specialist training areas that people might elect to attend. In addition to the training provided in-house the staff members also had access to the training provided by Neath Port Talbot Social Services Training Unit. It was noted that the staff had a good range of training available to them to support their work.

There was an expectation that all care staff were supervised on a monthly basis by the assistant unit leaders and formal records were maintained of these sessions. These were not inspected during this inspection episode. Assistant unit leaders were themselves supervised by the unit leaders. The Assistant Managers were supervised by the Manager of the Centre who had his professional supervision with the Assistant Director for Children's Services.

The staffing policy required three members of staff to work on each shift during the day although it was normal to have four staff on each unit. There is a risk assessment carried out and only one of the three units would be able to operate with less than four staff. A Duty Manager was nominated for each shift and at the weekends a Manager would be available on call if a Unit Leader was in the Duty Manager position.

The staff worked in teams, allocated to one unit and normally they remained on that unit although there were times due to issues of gender or risk assessment when staff might move to different units. An assistant unit leader who was responsible for the shift led the staff groups. Following a job evaluation staff stated that all staff were expected to take responsibility on a shift.

There were support systems in place for the staff and there was good practice acknowledged in the phased return to work for staff who had been on prolonged absences. There was also recognition of the impact upon the individual staff members of incidents involving the young people and staff indicated that they were supported through these times.



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New requirements from this inspection:

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Good practice recommendations:	NMS or other source

Section 6 – Conduct and management of the service

Hillside is part of Neath Port Talbot Social Services Children's Department, however, it is financially independent of the Department's budget. It is a self-financed cost centre and had always remained within budget. The accounts were audited in October 2008 and there were no recommendations made as a result of this visit. There were plans to extend the provision to 24 beds and in order to meet the costs the National Assembly for Wales were to meet the capital costs of the building. In addition to extra bedrooms the centre was to benefit from additional workshop areas which would provide a more varied educational provision and could only benefit the young people.

The centre manager had many years experience of working with children and young people in a variety of settings across England and Wales in both fieldwork and residential care. He was appointed to the position of centre manager in 1998 and since that time he had demonstrated his management skills and knowledge of the specialist area of work. The manager held the NVQ level 4 and 5 in Care and Management to meet the requirements of the Children's Homes (Wales) Regulations.

The centre had three assistant managers who each had specific areas of responsibility; professional services, operational management and education. There was also a senior administration officer who was part of the management team.

Monthly performance reports were produced by the centre which were scrutinised by the management team and from them the centre manager produced quarterly reports for the Children's Overview and Scrutiny Sub-Committee on the operation of the centre. The monthly reports were comprehensive covering information on the young people, staff, individual units, type of sanctions, restraints, incidents, accidents, supervisions, additional hours worked. From these monthly and quarterly reports it was possible for the centre to identify trends in the operation of the home. It was also apparent that the Children's Overview and Scrutiny Sub-Committee picked out details from the reports requiring clarification and followed through from one quarter to another.

Part of the contractual arrangements between the Youth Justice Board and Hillside require monitoring of the operations of the centre on a monthly and quarterly basis, with reports provided to the Youth Justice Board. The centre produced an annual business plan for its operation, which identified 12 key issues to be formulated into "positive objectives" during the year. The business plan was reviewed after six months and contained a risk assessment of the actions to be addressed. The plan showed a balance between addressing issues identified and future development.

Regulation 32 visits were carried out monthly by a member of the Contracting Department of Neath Port Talbot County Borough Council who had no line management responsibility for the centre. The individual responsible for the visits was a Contracting Officer for Children and Young Persons Services for Neath Port Talbot County Borough Council. These visits were recorded and reports forwarded to the centre manager. It was clear that any issues raised were followed through and checked upon at the next visit to the home. The visits were unannounced and carried out on different days and at different times. These reports were also provided to the Children's Overview and Scrutiny Sub-

Committee.

A Copy of the most recent inspection report from the Care and Social Services Inspectorate Wales was available in the reception area for any visitor to read.

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New requirements from this inspection:

Action required	Timescale for completion	Regulation number

Good practice recommendations:	NMS or other source

Section 7 – Concerns, complaints and production

Each unit maintained a complaint book and inspection of these confirmed that the young people were taking the opportunity to complain and the complaints were taken seriously by the staff. The outcomes of enquiries into any complaint were recorded concluding whether or not the complaint was upheld and the actions taken to resolve it. The centre was clear that any complaint arising from a situation of physical restraint would be reported to the Child Protection Officer for Neath Port Talbot County Borough Council and a strategy meeting would be held following medical examination if it was considered necessary. There were 48 recorded complaints for the period from 1st October 2007– 30th September 2008

The Child Protection policy had been reviewed since the last inspection and was about to be adopted. This document had been produced by the assistant manager for professional services and took account of the All Wales Child Protection Procedures 2008. Neath Port Talbot County Borough Council had established a Safeguarding Children Board and the responsibilities of this multi-agency board were incorporated into the document.

The staff members were introduced to issues of child protection, abuse and neglect during their induction period and further training in the first year of employment. Further updates were provided during the next few years of employment. The assistant manager stated that staff members were aware of their responsibilities to ensure the safety of the young people in their care. They would report any concerns to the manager who would liaise with other parties following the Local Safeguarding Children Board arrangements. All of the young people were admitted with full histories and risk assessments carried out to indicate any risk of being abused or abusing others. The Assistant Manager, Professional Services was responsible for maintaining the records for any child protection issues which included any historical disclosure made by the young people whilst resident in the Centre. Inspection of the records confirmed that the staff did pick up on any concerns and recorded them appropriately.

The staff members were observed to be very aware of the issues of bullying or the potential for it to exist in the centre and discussion in relation to one new admission were observed during handover. Any young person observed to instigate any issues of bullying would immediately be removed by staff for individual "talk time" and if considered appropriate the children's meeting would be used as a forum to discuss issues. A clear message that bullying would not be tolerated was included in the children's guide.

Discussion had been held with the manager about notification of significant events and there was obviously a clear understanding of when this was required and to whom. There had been one significant event notified to the Care and Social Services Inspectorate Wales in the previous year, although returns indicated that the police had been called to the centre on three occasions in the past year.

There were clear guidelines for the staff to report any young person missing from the centre. The opportunity for young people to go missing was mainly during mobility or court attendance. Prior to any occasion when young people were taken out from the

centre comprehensive risk assessments were carried out which included the number of staff who would accompany any mobility. Court attendance was organised through escorts who collected and returned the young people through the admission suite. There had been one instance of a young person going missing in the previous year when attending Court and he was not in the care of the staff from Hillside.

Requirements made since the last inspection report which have been met:

Action required	When completed	Regulation number

Requirements which remain outstanding:

Action required (previous outstanding requirements)	Original timescale for completion	Regulation number

New requirements from this inspection:

Action required	Timescale for completion	Regulation number

Good practice recommendations:	NMS or other source
Some bedrooms were in need of refurbishment	

Section 8 – Physical environment

Hillside is a purpose built secure children's home with education provided on the premises. It opened in 1996 as an "All Wales" provision for young people who require secure care due either to the risk they present to themselves or to the community through repeated or serious offending behaviour. There is a large car parking area at the front of the property accessed via a security barrier and buzzer to the receptionist. The front of the centre has the main reception area accessed via two locked doors for which the receptionist required identification. The administrative offices and the managers' offices are at the front of the building along with the open unit. The open unit has not operated as a unit since the centre opened and was being utilised for additional office and meeting rooms. There were plans to convert this unit into training rooms and office suites. Access to the corridor leading to the units is through double locked doors and off this corridor is the main kitchen, conference room, staff room, visitors room and admission suite. The educational rooms are on the right hand side and the three units, each able to accommodate six children are sited at the rear of the building off a central core. There is a sports hall, fitness suite and outdoor astroturf area in addition to the enclosed gardens available to each unit. The units each have an office, which overlooks the main lounge / dining area, quiet room and unit kitchen. From this area led two wings which each had three en-suite bedrooms. Each of the bedrooms has a buzzer to call staff with a switch off at source control and panel in the office to indicate which bedroom. There was no air conditioning in the centre, however, each of the bedrooms had natural air vents which could be individually adjusted. A future development might be to have air-conditioning in the communal areas. The building had under floor heating, which takes time for the temperature to adjust.

In addition to the en-suite there is a unit bathroom if the young people prefer to bath and a laundry and key-worker room. The admissions suite is accessed at the side of the building alongside Nedd Unit with access through to this unit or the corridor leading to the other units. There is a visitor's flat available at the front of the building which families can book if they require accommodation.

One of the bedrooms was designed to accommodate a young person with a physical disability with wider doorway access and lower surface levels. The centre is all on one level for the young people apart from the access to the sports hall. Any visitor to the home would be able to access either via a ramp or steps at the front of the building.

The communal areas in each of the units had been redecorated in the previous year but again were in need of some attention. Some of the furnishing in the units had been recovered in the past year which had been viewed as an improvement by staff. The tables and chairs showed signs of wear and tear and some required replacement. Some of the flooring was also showing signs of wear. The young people who were due to spend longer periods in the centre were able to personalise their own bedrooms through painting. Other bedrooms were in need of painting and the programme of upgrading the bedrooms had been on hold until the major extension was underway. Whilst this decision is understood some of the rooms should be attended to before the refurbishment.

Storage had been a problem in the Centre, however, the workstations in the unit offices were much tidier and each staff member had been provided with a tray which they were expected to empty daily. Also in the past year the staff had also been provided with lockers in the staff room to leave their personal possessions away from the units.

The new CCTV cameras installed had provided a much improved facility with enhanced clarity of picture. It was stated that there were some difficulties in picking up the area where an alarm was sounded.

Agreed responses had been drawn up with the emergency services in the event that they were required to attend to the building. The centre had a policy to shorten the electrical cords for any electrical item placed in a young person's room. Due to security the young people were able to personalise their rooms with posters but had to make use of toothpaste to attach them to the walls. The staff members carried out security checks on the units twice daily. Rechargeable torches were kept on charge on each unit.

Once the young people were in bed there were 15 minute checks carried out by two staff until eleven o'clock when the night staff were on their own. In some instances the young people had been assessed as requiring more regular checks. The staff recorded the times of checks and the time that the young person went to sleep. If a young person wanted to make use of their en-suite the member of night staff would call upon a staff member from another unit or the sleeping in staff to accompany them.

The centre had dedicated cleaning staff who were usually on the units when the young people were in education. They also were issued with keys and alarms which were booked in and out of the reception area.

Portable appliance testing and chlorination testing was underway at the time of inspection.

Requirements made since the last inspection report which have been met:

Action required	When completed	Regulation number

Requirements which remain outstanding:

Action required (previous outstanding requirements)	Original timescale for completion	Regulation number

New requirements from this inspection:

Action required	Timescale for completion	Regulation number

Good practice recommendations:	NMS or other source

Section 9 – Specialist provision

Discussion with staff and young people and observation of practice indicated that whilst Hillside was purpose built as a secure centre for young people it very much operates in a child centred manner. The young people are cared for as children first and the secure nature of this provision is incorporated into this.

Requirements made since the last inspection report which have been met:

Action required	When completed	Regulation number

Requirements which remain outstanding:

Action required (previous outstanding requirements)	Original timescale for completion	Regulation number

New requirements from this inspection:

Action required	Timescale for completion	Regulation number

Good practice recommendations:	NMS or other source