Wellhouse RCU
Care Home Service

Glasgow

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Glasgow City Council

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About the service

Wellhouse Residential Children's Unit is a residential care home for children and young people who are looked after and accommodated by Glasgow City Council. It is a purpose-built house in the Easterhouse area of Glasgow, which is on two levels, with one bedroom, which is accessible for a disabled young person, on the ground floor and the remainder of the bedrooms on the upper floor.

The accommodation comprises:

- Eight en-suite bedrooms;

- Two lounges, both with televisions;

- A large dining kitchen;

- One toilet;

- One bathroom;

- An office;

- A large garden;

- A laundry room.

At the time of inspection, six young people were resident within the service.

It should be noted that this inspection took place during the Covid-19 pandemic restrictions and therefore followed a revised procedure for conducting inspections in these circumstances.

What people told us

During this inspection we spoke to three young people individually and another one young person when they were around the house. We also observed several of the young people interacting with staff. We observed some warm and nurturing relationships.

Young people we spoke with gave us mixed views about the care and support they received, and we were concerned to hear that not all young people felt safe living in Wellhouse. This was evident from our discussions with one young person where they told us that they did not feel respected and expressed extreme unhappiness about their care. We heard that young people had voiced similar concerns to external professionals. Another young person also told us that they did not feel safe due to the behavioural presentation of other young people.

We also spoke to three family members/carers, who told us that they were happy with the support for their child or relative and in most instances, that staff communicated well with them, and they were made to feel welcome. Overall, parents/carers who spoke with us, were happy with the support for them and their family.

How well do we support children and young people's wellbeing? 2 - Weak

During this inspection, we found that young people's right to feel respected and experience dignity in their lives, was compromised by significant concerns about their safety and wellbeing. More than one young person that we spoke with during inspection, told us that they did not feel safe. We received feedback from more than one source that one young person felt there had been instances where they had been discriminated against due to the complexity of their needs.

Whilst we recognised that staff worked hard to provide nurturing care for young people, it was clear that the behavioural presentation of some young people, had and continued to impact significantly on the ability of young people to feel comfortable in their own home. For example, some young people living in the service told us about being impacted by the aroma of an illicit substance being used within the house and that they didn't like it. Our observations during inspection confirmed this. Although this was the case, we also heard that young people felt able to approach staff if they had concerns, but evidence showed that there was little impact of positive change.

Where consistent relationships were in place for young people, we found that staff made positive efforts to know them well. Some young people were helped to experience childhood play and other experiences they had missed in their early years. For example, water play and climbing activities which promoted fun and stimulation and a positive sense of growth. For others we found examples of age-appropriate activities. These promoted skills of co-operation and developing peer relationships and building trust.

However, staffing changes throughout the past inspecting year had impacted significantly on the continuity of relationships for young people. We heard from young people, staff and professionals involved with the service, of the many changes and ways in which this influenced outcomes for young people. For example, for periods throughout the past year, there was a lack of clarity about who would be providing supports each day and this meant that in some instances, young people were supported by staff who had limited knowledge of their needs and wishes, and key aspects of their care were not progressed in a timely manner.

We spoke with advocacy workers who told us that some young people had used this service to raise concerns about aspects of their care. We were concerned to hear that young people did not always feel listened to and that some felt unsupported by staff and did not like living in the house. In our discussions with a range of people involved with the service, we heard about perceived unfairness experienced by some young people, and this was evidenced through review of a large number of complaints made by young people in the past year. We felt that secure and valued relationships had not been experienced by some young people living at the service.

We did identify some strengths in terms of young people being supported to maintain contact with their friends/carers and peers. This helped to support their sense of belonging and identity.

Additionally, some young people were attending school and were doing so regularly. We found examples of young people achieving national qualifications and some were supported to participate in key events online. We also found that one young person had shown initiative to gain employment and it was clear that this offered them a real sense of achievement and self-worth.

It was evident that the combination of young people living at Wellhouse during this inspecting year presented significant challenges to their care and support. The importance of robust matching procedures was a key consideration of this inspection and experiences and outcomes for young people as a result, were

varied and in some instances, poor. We acknowledge that the service had been pro-active in moving some young people on from the service and that the outcomes for all had been positively impacted. It is accepted that children and young people should be kept safe, physically and emotionally at all times within their residential care environment. We were of the view that this was not always achieved for all young people living in Wellhouse.

Risk assessments were mostly up to date, however, the majority lacked clear strategies to combat risk. The lack of clear strategies meant that inconsistent approaches limited positive outcomes for young people and further, incidences of inconsistent practice, were also evidenced through an inflexible approach to risk management, which meant that the quality of some young people's experiences were lessened by assumptions about what was safe or possible. We also reviewed incident records over several months and young people's personal files and we found no analysis which meant that there was no evaluation of young person specific needs and no implemented strategies to reduce risk as quickly as there should have been.

We saw that not all young people had a completed missing person profile, and some crucial information was absent, such as a photograph. Given the risks presented by some young people living in Wellhouse we were of the view that these records required to improve in order to promote their safety and wellbeing. Furthermore, there is a need for the service to consider the status of young people whose whereabouts were at times unknown. We were confident that the service was already discussing this with police colleagues.

Although the service was now experiencing a more settled period and there were early signs of more routine and supportive interactions and relationships between most young people and staff, there were, however, examples where secure attachments were not evident along with concerns that consequences to behaviours were not consistently applied by staff and this meant that there was a lack clarity for young people about what to expect. Some young people clearly felt that being valued was contingent upon good behaviour.

We were satisfied to find that all young people had been registered with a GP and dentist and we saw recent evidence of young people being supported to attend for dental and hospital treatment. Additionally, we also acknowledged that young people had requested input from health services to address concerns about their mental health. However, we were concerned about the behavioural and eating habits of some young people and believed that without further attention and support these would continue to impact on outcomes for these young people's health and wellbeing.

Within the context of healthy eating, we also saw limited evidence of young people being provided with nourishing and freshly prepared meals. We found that there was a risk to the health outcomes for young people as staff voiced anxiety about the fridge/freezer door being broken which was resulting in spoilt food having to be regularly identified and thrown out. We had serious concerns about the health and safety implications of the house fridge/freezer door being broken for a time. We contacted the relevant department who advised that miscommunication from the service had delayed the necessary action being taken.

During our review of young people's files, we found that opportunities for young people's views to be captured was missing. Staff recording was not insightful, reflective or analytical and therefore did not inform staff to develop strategies of support which might have been helpful to the young person. There were very limited key worker records containing the views and wishes of some young people. We felt that this limited a more consistent understanding of their needs and wishes, amidst the wider staff upheaval throughout this inspecting year. The lack of evidence to inform the development of trusting relationships led us to question ways in which the complex needs of young people were being met by the service. We were of the view that the service should look to improve recording practices which evidence relationship building and positive

experiences and outcomes for young people and which clearly evidence their views and wishes.

The approach to children and young people's participation was found to be superficial. Attempts to involve children and young people who are seen as difficult to engage were not given sufficient priority. We asked the service to continue to improve and develop its participation process. This would ensure that young people have a wide range of opportunities to express their views and promote good outcomes.

Overall, we felt that there were some strengths that could be identified but these were outweighed by serious and significant weaknesses in critical aspects of the services performance, such as the assurance of the young people's welfare and safety, which substantially affect people's experiences and outcomes. This informed an overall grade of weak for this key question.

Requirements

1. The provider must ensure that recording practices are improved to ensure accountable and safe practice to meet the needs of all young people. In order to achieve this the provider must:

- Evidence nurture and compassion, participation and recording of 1:1 time and ensure there is improved recording of key events.
- Risk assessments and missing person profiles must be updated to accurately reflect each young person's needs and any strategies required to combat risk. Young people's views and wishes should be sought and recorded as to how they should be supported, especially during times of crisis.
- The provider should have in place detailed information to inform the strategies used, including the use of restraint, and that there is explicit multi-disciplinary consideration agreement about the use of all strategies.

This is to ensure that care and support is consistent with the Health and Social Care Standards which state: 'I experience high quality care and support based on relevant evidence, guidance and best practice' (4.11); 'I am supported and cared for sensitively by people who anticipate issues and are aware of and plan for any known vulnerability or frailty' (3.18); 'I am protected from harm, neglect, abuse, bullying and exploitation by people who are alert and respond to signs of significant deterioration in my health and wellbeing, that I may be unhappy or may be at risk of harm' (3.21); 'If I go missing, people take urgent action, including looking for me and liaising with the police, other agencies and people who are important to me' (3.23); 'My personal plan, (sometimes referred to as a care plan) is right for me because it sets out how my needs will be met, as well as my wishes and choices' (1.15); 'I am supported and cared for sensitively by people who anticipate issues and are aware of and plan for any know vulnerability or frailty' (3.18); 'I experience high quality care and support based on relevant evidence, guidance and best practice (4.11); 'My care and support is provided in a planned and safe way, including if there is an emergency or unexpected event' (4.14).

This is also to comply with the Social Care and the Social Work Improvement Scotland (Requirements for Care Services) Requirements 2011.

Areas for improvement

1. The service should make demonstrable efforts to ensure that children and young people enjoy a healthy and well-balanced diet, that the health needs of young people are prioritised and closely monitored and that the health and safety of the home is adequately maintained.

This is consistent with the Health and Social Care Standards which state: 'I can choose suitably presented and healthy meals and snacks, including fresh fruit and vegetables, and participate in menu planning' (1.33) and 'I am supported to make informed lifestyle choices affecting my health and well-being, and I am helped to use relevant health and screening services' (1.28).

How good is our leadership? 2 - Weak

During this inspection, we were unable to assess ongoing improvements in young people's outcomes which had resulted from any effective and robust quality assurance processes both within the service and from external managers. Whilst we saw some records relating to staff supervision, team meetings and managers meetings, there was significant gaps in frequency for all of these and the quality of recordings was poor, and an oversight of young people's needs was not apparent. In notes of the manager's supervision from January of this year, we saw that staff supervision and team meetings were identified as a priority. Similarly, we found reference to disorganisation and lack of process in a note dated May 2021. Overall, there were clear and significant failures to identify and implement improvements relating to the safety and wellbeing of young people or broader service developments. We were also concerned about a lack of formal structures or evaluations of learning, and actions, arising from complaints made to the Care Inspectorate to support continued improvement within the service. Additionally, there was extremely limited evidence of auditing and oversight of key processes. The lack of clear, consistently implemented, quality assurance practices meant the service was ineffective in identifying and improving necessary outcomes for children and young people in a responsive manner.

We received a list of tasks identified by the service, as requiring to be progressed. We saw no evidence of improvement planning, taking account of the views of key partners, including young people or staff. We considered the service had no clear plan for how it intended to achieve these tasks and lacked a sense of direction or ambition. We would request that the service develop an improvement plan which will show evidence of progress within the service, and which is SMART (specific, measurable, achievable, realistic and time-bound). This would help ensure that identified items are monitored and their progress tracked and sustained and would act to evidence a strong commitment to ongoing improvement, focused on outcomes for young people.

Whilst we saw that feedback had been sought from professionals, and this provided a mixed picture of views about the overall care and support for some young people, we also received less positive remarks from certain professionals relating to how young people felt valued and cared for. We were aware that the service had yet to seek views of young people and their families and clearly this will be an important development towards improvement planning.

Although we recognised that the new manager intended to promote a more nurturing culture within the staff team and we observed some warm practice with some young people, we also heard from some staff that they were unhappy about changes to existing practices, which they stated had been made without consultation. We heard during some staff interviews that changes had caused some division in the team and although we found reference to this in some records, there seemed to be no evidence of how this was being addressed systematically by managers. We were concerned that some young people made reference to this during our visit, in terms of how it impacted their care. It would be helpful going forward to conduct a consultation with staff about their views.

We found good evidence that young people were able to make complaints and that these had been responded to by managers. However, consistent themes of perceived unfairness remained despite any

response given. It could easily have been perceived that the relationships between some young people and managers remained in conflict over a prolonged period of time resulting in deterioration of key supports. Four separate complaint allegations to the Care Inspectorate relating to the running of the service were utilised to inform the focus of this inspection.

An important part of quality assurance relates to the monitoring, reporting and analysis of serious incidents. We heard of, and read about, a number of significant incidents which should have, but had not, been notified to the Care Inspectorate. Whilst we know the that the external manager had conducted analysis of violent incidents, we found no evidence of how this informed reflective practice within the staff team or mitigated risk in a timely manner for young people. This meant that we found no evidence of patterns or trends of the impact of behaviours, for young people or staff involved and also no communication to the staff team to influence clear improved strategies in risk assessment processes.

Overall, we felt that there were some strengths that could be identified but these were outweighed by serious and significant weaknesses in critical aspects of the services performance, such as the assurance of the young people's welfare and safety, which substantially affect people's experiences and outcomes. This informed an overall grade of weak for this key question.

Requirements

1. The provider must ensure that robust quality assurance records and practices (internal and external) are in place, to evidence the effectiveness of the service, in meeting the needs of young people.

This is to ensure that care and support is consistent with the Health and Social Care Standard which states: 'I benefit from a culture of continuous improvement, with the organisation having robust and transparent quality assurance processes' (4.19).

This is also to comply with the Social Care and the Social Work Improvement Scotland (Requirements for Care Services) Requirements 2011.

2. To ensure that young people have confidence in the service providing their care and support, the provider should develop and implement an improvement plan which is SMART and fully incorporates the views of young people, the staff team and other partners.

This is to ensure that care and support is consistent with the Health and Social Care Standards which states: "I benefit from a culture of continuous improvement, with the organisation having robust and transparent quality assurance processes" (HSCS 4.19).

This is also to comply with the Social Care and the Social Work Improvement Scotland (Requirements for Care Services) Requirements 2011.

3. The provider should ensure that they access the up-to-date Care Inspectorate guidance on notifications and notify us in accordance with this guidance. In addition, the provider should ensure that there is a systematic process for analysis of incidents over time so that any learning can be identified. This should include the learning from staff de-briefs.
This is to ensure that care and support is consistent with the Health and Social Care Standard which states: 'My care and support meets my needs and is right for me' (1.19); 'I am protected from harm, abuse, bullying and exploitation by people who have a clear understanding of their responsibilities' (3.20); 'I experience high quality care and support based on relevant evidence, guidance and best practice (4.11) and 'I

benefit from a culture of continuous improvement, with the organisation having robust and transparent quality assurance processes' (4.19).

This is also to conform with the Public Reform Act 2010 Section 52 (6).

This is also to comply with the Social Care and the Social Work Improvement Scotland (Requirements for Care Services) Requirements 2011.

How good is our staff team? 2 - Weak

We heard from a range of partners that, despite the unsettled nature of the house over a prolonged period of time, the staff team at Wellhouse were working hard to care for young people in a nurturing way and we saw evidence of warm relationships between individual members of staff and some young people.

However, during our inspection we were not provided with sufficient evidence which enabled us to see that staff were given adequate time for effective, structured supervision, or support through regular on-going planned team meetings. We did however acknowledge that despite decreased management presence, day to day support was in place. Limited opportunities for reflection had resulted in a staff group not being provided with appropriate frameworks to address the changing needs of young people. We reviewed a large sample of staff supervision records and found them to be generally lacking in evidence of an appropriate space to reflect, with limited discussion and identification of ongoing professional development needs. The quality of records, where these existed, were extremely poor for some staff, including senior staff. This was especially concerning given the formation of a new management team in the early part of 2020. We also found an inconsistent approach to de-briefs following incidents. Such support is crucial to improved outcomes for young people as it supports the guidance given to staff and the development of a workforce that can respond to risk more consistently and feel safer to practice, particularly in the challenging circumstances experienced by the service over the recent past. Given the complexity of young people who have lived and continue to live at the service over this past year, a fully supported workforce was needed to meet their needs.

We were told that staff do not have a personal development plan and no annual appraisal takes place. This meant that there was limited evidence of monitoring and development of staff values, skills and knowledge and their application to practice and in turn limited assessment of their competence and development to support young people.

We heard from staff and young people that there was inconsistency of care and support being provided and we reviewed a sample of staff training records to inform our assessment of this. Whilst there were some positive examples of core learning outcomes, we found limited evidence of practice-based training and how this was used to support outcomes for young people. We were particularly concerned that there were limited training opportunities, specifically based on meeting the range of complex needs of young people living in the service, and this was compounded by the lack of readily available information on what training staff had completed. As a result, there was no evidence-based analysis of skills and subsequently no assessment of skill mix on shifts.

In relation specifically to Promoting Positive Behaviour training, we acknowledged the impact of the Covid-19 pandemic. However, given the serious nature of the on-going challenges presented by a number of young people, some of whom have since moved on from the service, we would have expected to find alternatives to refresher training to enhance the welfare and safety of young people and staff. The service did not have available the records relating to the numbers of staff who were trained/untrained in restraint

techniques and therefore we concluded that there had been no recorded analysis of the skill mix for rota planning or that this had been a component of matching of admissions.

We observed that there were enough staff on shift each time we visited and where flexible arrangements were needed, we saw that staff stayed on and waited for colleagues to arrive, prior to leaving for the day. Rotas also showed that staff were supportive of one another where gaps in staff cover were evident. The importance of effective quality assurance practices and staff training was highlighted by our findings regarding significant staff turnover within the team as well as staff sickness levels which had resulted in a significant use of peripatetic staff, many of whom had no prior knowledge of the young people. Young people and staff told us about a period when they did not know who was coming to work in the service each day and also that different peripatetic staff had been assigned. Feedback from external professionals confirmed these views. We believe this practice did not support continuity of trusting and enduring relationships for young people and limited the potential for them to achieve improved outcomes. Whilst we acknowledge that the provider made consistent efforts to address staff shortages and turnover during the Covid-19 pandemic, we remained concerned about the significant impact on outcomes for young people living in the service during this time. The use of peripatetic staff meant that training and quality assurance should have been of upmost importance, however, we were of the view that high level staff changes result in a lack of enthusiasm and commitment to drive improvements for young people. It was clear that disrupted relationships meant that young people found it difficult to cope with daily life at the service for a significant part of 2020 and beyond.

A range of evidence we saw led us to be concerned about the lack of consistency in direction to staff and responses to some young people. We felt that this contributed to poor outcomes for some young people and that their sense of worth and self-respect was impacted. Our review of complaints made by young people confirmed their perceptions of unfairness of staff practices and decision making. During our visit, young people expressed a range of views about their supports. Some confirmed that although they liked members of staff, they did not feel safe living at the service, while others also told us that the differing approaches by managers and staff, led to them feeling distressed and disrespected. From the views of young people and those of some staff and other professionals, it was clear that staff did not always work well together, and this had a detrimental impact on some young people's care and support.

Overall, we felt that there were some strengths that could be identified but these were outweighed by serious and significant weaknesses in critical aspects of the services performance, such as the assurance of the young people's welfare and safety, which substantially affect people's experiences and outcomes. This informed an overall grade of weak for this key question.

1. The provider must ensure all staff are sufficiently confident, skilled and experienced to look after young people with highly complex needs and safely manage unplanned escalated behaviours. The service must undertake a training needs analysis for each member of staff.

This is to ensure care and support is consistent with the Health and Social Care Standards, which states: 'I have confidence in people because they are trained, competent and skilled, are able to reflect on their practice and follow their professional and organisational codes' (3.14); 'I experience high quality care and support based on relevant evidence, guidance and best practice' (4.11).

This is also to comply with the Social Care and the Social Work Improvement Scotland (Requirements for Care Services) Requirements 2011.

2. The provider should put in place a coherent system for assessing the staffing levels and skills that are required, taking into account young people's physical, emotional, and social needs. They should review and record this on a four-weekly basis in line with Care Inspectorate guidance.

This is to ensure care and support is consistent with the Health and Social Care Standards, which state that 'My needs are met by the right number of people' (3.15).

This is also to comply with the Social Care and the Social Work Improvement Scotland (Requirements for Care Services) Requirements 2011.

1. The service should ensure that staff, including the manager, have regular opportunities for good quality supervision and that this takes place in line with their supervision policy. We would further ask that systems of staff appraisal are implemented for all staff.

This is to ensure care and support is consistent with the Health and Social Care Standards which state that 'I have confidence in people because they are trained, competent and skilled, are able to reflect on their practice and follow their professional and organisational codes' (3.14), and with the SSSC's Code of Practice for Employers of Social Service Workers, which state that the employer will 'provide effective, regular supervision to social service workers to support them to develop and improve through reflective practice' (3.5).

How good is our setting? 3 - Adequate

During this inspection we heard of positive examples of staff supporting young people to maintain relationships with family and friends and those young people benefited from having these meaningful connections. Feedback from the majority of family members/carers was positive and we heard that they were happy with the supports for their child/relative and that staff on the whole communicated well with them and they were made to feel welcome.

We heard about and saw photographic evidence of some young people being supported to enjoy fun activities and outings. We saw that some young people had friends through attending school and in one instance a young person had successfully sought employment and was sustaining this on a part time basis. However, we did not find evidence of outcomes where young people's care plans had identified involvement in local groups, and we would have expected to see evidence of how young people were being supported to gain the social skills required to integrate into their local community in ways most suited to their needs and wishes. Improved use of recording of 1:1 time would support the service to evidence such discussions, activities and planning for the use of young people's free time.

We were concerned to find that for some young people, the local community was not a safe place and we felt that risk management practices did not always take account of the wider needs of some young people. We were additionally concerned to find that some young people did not feel safe within the house. In some instances, young people were frightened from other young people, while others told us that they did not feel supported to develop their own sense of personal safety.

Where young people felt enabled to enhance their personal space, we found that this improved their sense of belonging. For example, through choices of decoration to reflect their personalities and personal taste. Despite this, we heard from almost everyone we spoke with that the behaviours of some young people had caused extensive damage to the house and during this inspection, we saw those efforts to improve the environment had not fully impacted positively on the overall sense of warmth.

Although the provider had a policy of issuing each young person with their own laptop, we found that security concerns meant that laptops required to be kept locked away, to prevent the risk of theft. We were also informed that the internet connection for the house was unreliable, and this meant that young people's ability to connect with the wider world was impacted and made more difficult. This extended to issues with privacy, where young people wished to conduct a meeting confidentially. Our evaluation was that young people living at the service remained technologically disadvantaged by virtue of living there.

Overall, we felt that there were some strengths but these just outweighed weaknesses. Improvements must be made by building on strengths while addressing those elements that are not contributing to positive experiences and outcomes for young people. This informed an overall grade of adequate for this key question.

1. The provider should ensure that security arrangements within the house are robust in ensuring the safety and wellbeing of young people and that this encourages a sense of safety and belonging.

This is to ensure care and support is consistent with the Health and Social Care Standards, which state: 'I am protected from harm, neglect, abuse, bullying and exploitations by people who have a clear understanding of their responsibilities' (3.20) and 'My environment is secure and safe' (5.17).

This is also to comply with the Social Care and the Social Work Improvement Scotland (Requirements for Care Services) Requirements 2011.

1. The service should make sustained effort to support children and young people to make meaningful links with the local community.

This is to ensure care and support is consistent with the Health and Social Care Standards, which states: 'I am supported to participate fully as a citizen in my local community in the way that I want' (1.10).

How well is our care and support planned? 2 - Weak

We reviewed young people's records, including daily logs. Many of these were addressed to the young person and written in a positive and supportive way.

We found some evidence of multi-disciplinary involvement in the care planning and review process. However, during our review of four young people's plans, we felt the standard of personal planning was weak, with limited attention to optimising the strengths of young people. We found little evidence that young people's views and wishes had been sought and incorporated into their plans. A lack of quality assurance resulted in static or very recently compiled plans, meaning that for some young people they were not leading and directing their own care and support in ways that were meaningful to them as individuals.

We found that assessment and personal planning was not based on SMART (specific, measurable, achievable, relevant and time-bound) outcomes and plans were not used to deliver care effectively for every young person. The complex needs of young people were not reflected in the frameworks of practice and staff changes meant that there was a lack of awareness of the individual plans for each young person. We also found that some young people's personal plan had not been updated for a period of more than six months, while others had been reviewed in line with guidance and legislation. Lack of quality assurance led to delays in progressing plans and prolonged delays to the implementation of alternative strategies. As a

regulated service, there is a requirement for all young people to have a personal plan, detailing how the service will support them with their health, welfare and safety needs. Due to the highly complex and rapidly evolving needs of young people, a regularly and responsively amended care plan to these changing circumstances would have been expected in order to more effectively influence and guide and evaluate interventions. Plans lacked high-quality evaluation of young people's development and progress and little evidence of young people leading on their own care and support and as a result, alternative care planning interventions were not identified earlier.

Risk assessment and behaviour support plans were up to date but did not sufficiently detail strategies to combat risk for most young people. The risks therefore were not clearly managed, or quality assured which meant that poor quality outcomes persisted longer than might have been expected. We were unable to confidently see how the broader care plan for young people influenced the work of staff or key working conversations with young people and there was a lack of clarity about outcomes and timescales. Improvements would enable staff to be clearer about how to support young people to achieve the goals within their plans and identified outcomes could be better linked to daily life and current aims for the young person.

We acknowledged the positive developments regarding the new My Plan model of reviewing young people's care and welcomed the involvement of an independent reviewing officer in promoting a focus on listening more closely to young people's views and wishes. We heard from the reviewing officer about positive opportunities for independent evaluation and constructive challenge. However, we found more limited effectiveness in how this translated into the young peoples' personal plans and focused improvements on how young people's outcomes were being promoted. Ongoing outcomes were not evidenced in the files we sampled. For example, where young people had recently secured employment, we would have expected to see how the service was supporting them with issues arising from this achievement such as managing monies and promoting an improved diet. Similarly, where young people displayed poor social skills, the continued risk to their safety and wellbeing in the community was not addressed within their plan. In some cases, the outcomes of specific assessments did not appear to have informed plans for young people, with the potential for less positive outcomes.

We saw the involvement of professionals external to the service who worked in partnership to strive to influence young people's safety and wellbeing. The professionals we are referring to include advocacy, health professionals, social workers, the independent reviewing officer and Police Scotland. However, it was our view that some young people remained at risk in the service and community, and we found limited evidence of strategies being implemented to mitigate risk for young people who presented challenges or concerns quickly and effectively.

Overall, we felt that there were some strengths that could be identified but these were outweighed by serious and significant weaknesses in critical aspects of the services performance, such as the assurance of the young people's welfare and safety, which substantially affect people's experiences and outcomes. This informed an overall grade of weak for this key question.

Requirements

1. The provider must ensure that care plans are developed in consultation with young people to reflect their individual choices and preferences. Care plans should reflect a responsive, person-centred approach. The service should ensure that goals identified within care plans are SMART (specific, measurable, achievable, realistic and time-bound). This would enable staff to be clearer about how to support young people to achieve their individual goals and aspirations.

This is to ensure that care and support is consistent with the Health and Social Care Standards, which state that: 'I am fully involved in assessing my emotional, psychological, social and physical need at an early stage, regularly and when my needs change' (HSCS 1.12); 'My future care and support needs are anticipated as part of my assessment' (HSCS 1.14); 'My personal plan (sometimes referred to as a care plan) is right for me because it sets out how my needs will be met, as well as my wishes and choices' (HSCS 1.15) and 'I am fully involved in developing and reviewing my personal plan, which is always available to me' (HSCS 2.17).

This is also to comply with the Social Care and the Social Work Improvement Scotland (Requirements for Care Services) Requirements 2011.

Complaints

There have been no complaints upheld since the last inspection. Details of any older upheld complaints are published at www.careinspectorate.com.

Detailed evaluations

How well do we support children and young people's wellbeing?	2 - Weak
1.1 Children and young people experience compassion, dignity and respect	2 - Weak
1.2 Children and young people get the most out of life	2 - Weak
1.3 Children and young people's health benefits from their care and support they experience	2 - Weak

How good is our leadership?	2 - Weak
2.2 Quality assurance and improvement are led well	2 - Weak

How good is our staff team?	2 - Weak
3.2 Staff have the right values, skills and knowledge to care for children and young people	2 - Weak
3.3 Staffing levels are right and meet children and young people's needs, with staff working well together	2 - Weak

How good is our setting?	3 - Adequate
4.3 Children and young people can be connected with and involved in the wider community	3 - Adequate

How well is our care planned?	2 - Weak
5.1 Assessment and care planning reflects children and young people's needs and wishes	2 - Weak

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