Agenda Item No. 6(a)

South Ayrshire Council

Report by Head of Children's Health, Care and Justice to Cabinet of 29 October 2024

Subject: Unannounced Inspection of Cunningham Place Children's House

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1. Purpose

1.1 This report is to inform South Ayrshire Cabinet that there was an unannounced inspection by the Care Inspectorate on Cunningham Place, Children's House on 3 and 4 June 2024. This inspection was carried out by one inspector from the Care Inspectorate with in-person visits taking place and feedback provided on 9 June 2024.

2. Recommendation

2.1 It is recommended that the Cabinet:

2.1.1 acknowledges the Care Inspectorate's unannounced inspection of Cunningham Place Children's House and the grading of being Weak;

2.1.2 reflects upon the key messages from the Inspection report, and the requirements and recommendations highlighted; and

2.1.3 acknowledges the Health and Social Care Partnership's Improvement plan and is assured of the ongoing improvement work being undertaken.

3. Background

3.1 The Care Inspectorate undertook an unannounced Inspection of Cunningham Place Children's House in June 2024. They spoke with seven young people using the service and two family members; they also spoke with 11 members of staff, management, and representatives from social services and advocacy services. To inform the inspection further, they reviewed survey responses received from staff and external professionals, observed practice and daily life in the House, through being present within the House, and reviewed key documents.

3.2 The overall inspection assessed the House against the quality indicator; ***'How well do we support children and young people's rights and wellbeing?'*** The House's care against this indicator was ***Weak.***

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4. Proposals

4.1 The Cabinet is required to consider the key messages and areas for improvement noted by the Care Inspectorate:

4.1.1 Young people were making good progress through their plans;

4.1.2 The service was providing care to some young people under continuing care arrangements;

4.1.3 Staff training required to be developed to ensure all staff have an understanding of trauma informed care and Children's Rights;

4.1.4 Care provided to young people was inconsistent which impacted on relationships;

4.1.5 Communication and information sharing required to be improved to ensure young people were kept safe; and

4.1.6 The leadership team required to take urgent and decisive action to improve service delivery.

4.2 Overall the Inspectors said:

4.2.1 Some young people expressed that they felt safe in the service, and all young people had access to independent advocacy. We found that there were risks to young people's safety, with some young people stating that they felt excluded at times. This compromised young people's quality of relationships with staff, the atmosphere within the home, and young people's emotional wellbeing (see requirement 1).

4.2.2 Staff were not consistently providing trauma-informed care. We found that there was a lack of therapeutic work undertaken with young people, and strategies used to support young people were absent or unclear. This meant that the care provided to young people was inconsistent and staff's responses to young people were, at times, insensitive and did not support their emotional wellbeing (see requirement 1).

4.2.3 There was a limited knowledge of children's rights and how to support young people's rights. This included understanding the roles and responsibilities of a corporate parent and the UN Convention on the Rights of the Child (UNCRC). This meant that young people's rights were at times compromised (see requirement 1).

4.2.4 Young people and staff raised concerns about the quality of the food at mealtimes, and we have asked the service to take this forward.

4.2.5 Young people were supported to access services including health, education and employment opportunities. Young people were also supported to maintain connections to people important to them. Some young people had decided to remain in the service after turning 16 years of age, under continuing care arrangements, and this was supported by the service. Young people's individual talents and interests were promoted, and involvement in activities was supported by staff. These

included sporting activities, holidays and outings, which meant young people were supported to access new experiences to enjoy.

4.2.6 All young people had care planning and risk assessment documents. It was pleasing to see that these had been developed since the last inspection. These documents were child-friendly, individual to the young person, and were strengths-based. Care planning documents could be developed further by being SMART-er (specific, measurable, achievable, relevant, and time-bound) and identifying effective, clear strategies to support young people and minimise risks. We had made an area for improvement in relation to risk assessments after the previous inspection. This area for improvement has been met.

4.2.7 The vision for the service was reflected in the service's improvement plan, which focused on children and young people's rights. It was pleasing to see that the service was documenting complaints, had introduced QR codes for young people to submit feedback, and had sought feedback from staff and stakeholders. Whilst it was pleasing to see that the service had used this feedback to inform aspects of service improvement, this had not always been effective. We found that there was a lack of urgent and decisive action taken by the managers and external managers (see requirement 2).

4.2.8 Many staff did not feel supported by the managers and external managers, nor did they feel that they benefited from regular advice and guidance through effective supervision, team meetings, handovers, or a supportive team of peers (see requirement 2).

4.2.9 Important information regarding young people was not consistently recorded or shared, which could compromise young people's safety and management of risk. Whilst all staff were aware of whistleblowing procedures, they did not have confidence in these, further compromising young people's safety (see requirement 2). We found that the service was not consistently notifying the Care Inspectorate, or that notifications lacked important information (see requirement 3).

4.2.10 The service supported young people's transitions to and from Cunningham Place, this included convening consideration meetings to ensure young people's support was planned. It was pleasing to see that the service had developed impact assessments since the last inspection, however these had not yet been implemented in practice. We had made an area for improvement in relation to admissions and matching after the previous inspection. Not all elements of this have been met and we have repeated this area for improvement (see What the service has done to meet any areas for improvement we made at or since the last inspection).

4.2.11 Staff training was tracked, identified, and offered by the manager, and development days were held, relevant to the young people's needs. The impact of training was limited due to the issues around poor communication and inconsistent practice. Staff were recruited through safe recruitment practices with all statutory checks being completed. Children and young people were actively involved in recruitment processes. New staff did not receive a thorough induction process (see requirement 4).

4.2.12 The staff team was stable with limited changes of personnel which provided familiarity for young people. It was also pleasing to see that the service had developed a staffing needs assessment since the last inspection. However, we found that there were times where there were insufficient numbers of staff on shift, and it was sometimes unclear what staff would be present in the service and when. This impacted on young people's ability to experience stable, therapeutic relationships (see requirement 4).

4.2.13 There were some quality assurance processes in place to monitor aspects of service delivery, however these were limited, and we were unable to assess their effectiveness. Whilst it was pleasing to hear that the service plans to develop quality assurance, there were currently no external processes in place. This meant that there was not a continuous and robust evaluation of children and young people's outcomes, experiences, and the setting, in place (see area for improvement 1).

Areas for Improvement

4.3 Copy Improvement Action Plan attached as Appendix 1.

Requirement 1:

By 30 August 2024, the provider must ensure that all staff have had relevant training. This is to ensure young people receive safe and consistent care.

In particular the provider must:

4.3.1 Ensure all staff have undertaken up-to-date child and adult protection training.

4.3.2 Ensure all staff have undertaken training in relation to trauma-informed practice.

4.3.3 Ensure all staff have undertaken training in relation to children's rights.

4.3.4 Develop a plan detailing how the service plans to embed a trauma-informed model of care within its ethos and culture.

4.3.5 Develop a plan detailing how the service plans to embed a children's rights based approach within its ethos and culture.

4.3.6 Identify effective and clear strategies to support children and young people.

Requirement 2:

By 30 August 2024, the provider must ensure that there is effective leadership to provide structure and support to the staff team. This is to ensure young people's needs are met and they are kept safe.

To do this, the provider must, at a minimum:

4.3.7 Ensure there is an experienced manager present within the service to prioritise the needs of the young people.

4.3.8 Develop and implement the service's improvement plan to address the culture within the service to create a supportive and open learning culture within the team.

4.3.9 Ensure that staff benefit from regular advice and guidance. d) Ensure that information is shared effectively within the team.

4.3.10 Ensure that incident recording includes important detail and is accurately recorded.

4.3.11 Ensure that staff are debriefed following an incident to support staff to reflect on their practice and how to best support the young people.

4.3.12 Ensure that staff receive regular and effective supervision to reflect on their practice and identify areas of practice for further development.

Requirement 3:

With immediate effect, the provider must ensure that to support effective scrutiny of the service, notifications are submitted in accordance with guidance, and that sufficient detail is added to accurately reflect the incident and provide assurance to the Care Inspectorate that the service is responding appropriately.

Requirement 4:

By 30 August 2024, the provider must ensure that there is the correct number of suitably qualified and competent staff on shift.

Areas for improvement 1:

To promote high quality care and support for all young people within a culture of continuous improvement, the provider should ensure that robust quality assurance processes are in place to promote improved outcomes for young people.

5. Legal and Procurement Implications

5.1 There are no legal implications arising from this report.

5.2 There are no procurement implications arising from this report.

6. Financial Implications

6.1 Not applicable.

7. Human Resources Implications

7.1 Not applicable.

8. Risk

8.1 ***Risk Implications of Adopting the Recommendations***

8.1.1 There are no risks associated with adopting the recommendations.

8.2 ***Risk Implications of Rejecting the Recommendations***

8.2.1 Rejecting the recommendations will have a negative impact on the achievement of the following strategic outcomes within the Service and Improvement Plan for the Health and Social Care Partnership. Namely; ***'Improving outcomes for care experienced children and care leavers'*** and *'**building communities in which people feel safe and are safe'*** and ***'being evidence-informed and driven by continuous performance improvement'***.

9. Equalities

9.1 The proposals in this report allow scrutiny of performance. The report does not involve proposals for policies, strategies, procedures, processes, financial decisions and activities (including service delivery), both new and at review, that affect the Council's communities and employees, therefore an equality impact assessment is not required.

10. Sustainable Development Implications

10.1 ***Considering Strategic Environmental Assessment (SEA)*** - This report does not propose or seek approval for a plan, policy, programme or strategy or document otherwise described which could be considered to constitute a plan, programme, policy or strategy.

11. Options Appraisal

11.1 An options appraisal has not been carried out in relation to the subject matter of this report.

12. Link to Council Plan

12.1 The matters referred to in this report contribute to all three priority areas of the Council Plan, particularly focus on wellbeing, improving life chances and reducing inequalities.

13. Results of Consultation

13.1 There has been no public consultation on the contents of this report.

13.2 Consultation has taken place with Councillor Hugh Hunter, Portfolio Holder for Health and Social Care, and the contents of this report reflect any feedback provided.

14. Next Steps for Decision Tracking Purposes

14.1 If the recommendations above are approved by Members, the Head of Children's Health, Care and Justice will ensure that all necessary steps are taken to ensure full implementation of the decision within the following timescales, with the completion status reported to the Cabinet in the 'Council and Cabinet Decision Log' at each of its meetings until such time as the decision is fully implemented:

Implementation	*Due date*	*Managed by Mark Inglis, Head of Service for Children's Health, Care and Justice*
To implement the identified improvements required in the Care Inspectorate's report and the associated Action Plan 1	August 2024	Head of Children's Health, Care and Justice

Background Papers **Care Inspectorate Report – 28 Cunningham Place Care Home Service – June 2024**

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Date: 21 October 2024

Appendix 1

Cunningham Place Action Plan – August 2024

Area for Improvement: Requirement 1		
By 30 August 2024, the provider must ensure that all staff have had relevant training. This is to ensure young people receive safe and consistent care.		
High Level Action	**Specific Action**	**Evidence**
1.01 Ensure all staff have undertaken up-to-date child and adult protection training.	1.01.1 Full audit of team training was undertaken and completed on 07/08/2024.	**Full service training matrix has been collated and will be consistently monitored, which shows level of training as well as outstanding training needs for all staff.**
	1.01.2 Child/Adult protection training and refresher dates to be set. Training dates to address gaps were circulated to relevant staff members as per attached emails.	**Dates set and training undertaken by all staff at the relevant level for both CP and ASP. The Training Matrix will allow**

Area for Improvement: Requirement 1		
By 30 August 2024, the provider must ensure that all staff have had relevant training. This is to ensure young people receive safe and consistent care.		
High Level Action	**Specific Action**	**Evidence**
		ongoing oversight and compliance.
	1.01.3 Ongoing monitoring of effectiveness of training ensuring it is embedded in practice.	**Training, learning, culture and practice are standing agenda items for team meetings and Supervision sessions now. Both templates have been revised.**
1.02 Ensure all staff have undertaken training in relation to trauma-informed practice.	1.02.1 Full audit of team training completed 08/08/2024.	**Attendance and requirements have been recorded and additional top-up sessions have been arranged for**

Area for Improvement: Requirement 1		
By 30 August 2024, the provider must ensure that all staff have had relevant training. This is to ensure young people receive safe and consistent care.		
High Level Action	**Specific Action**	**Evidence**
		those who need it.
	1.02.2 Trauma Informed training dates set for 06/08/24 and a mop-up session on 20/08/2024. This will be in the format of a Trauma Informed Training Workshop.	**Attendance is prioritised for all staff and is monitored. Impact is being assessed through team meetings, supervision and additional sessions with Angie P who also uses an evaluation to understand impact.**
	1.02.3 Ongoing monitoring of effectiveness of training to ensure it is embedded in practice, will happen through Team Meetings and by working in	**The revised Supervision and Team Meeting**

Area for Improvement: Requirement 1		
By 30 August 2024, the provider must ensure that all staff have had relevant training. This is to ensure young people receive safe and consistent care.		
High Level Action	**Specific Action**	**Evidence**
	partnership locally to initiate the process described in the Improvement Service's National Learning Report 2024: • **Understanding where we are now** • **Leadership, organisational culture and readiness** • **Staff care, wellbeing and support** • **Workforce capability and capacity** • **Strengthening policies, systems and services** • **Long-term improvement and sustainability**	**templates will ensure practice and the embedding of training are discussed regularly and any issues addressed quickly.**
1.03 Ensure all staff have undertaken training in relation to children's rights		
	1.03.2 Dawn Parker delivered UNCRC training, along with Promise training on 23rd of July and 30th of July, at County Buildings, Ayr.	**Training was delivered to all staff and Dawn ensured all staff received the same information. The sessions were evaluated, and additional inputs are planned in the**

Area for Improvement: Requirement 1		
By 30 August 2024, the provider must ensure that all staff have had relevant training. This is to ensure young people receive safe and consistent care.		
High Level Action	**Specific Action**	**Evidence**
		house with support from the Champion's Board.
	Ongoing monitoring of effectiveness of training to ensure it is embedded in practice will happen through Team Meetings, Supervision, and direct feedback from young people about their experiences through session(s) with the Champions Board.	**Team Meetings, Supervision and input from the Champions' Board along with evaluation of training sessions will increase understanding of effectiveness of training.**

Area for Improvement: Requirement 1		
By 30 August 2024, the provider must ensure that all staff have had relevant training. This is to ensure young people receive safe and consistent care.		
High Level Action	**Specific Action**	**Evidence**
1.04 Develop a plan detailing how the service plans to embed a trauma-informed model of care within its ethos and culture.	1.04.1 All staff will undertake training and, as a part of that, will complete a self-reflection tool which will provide insight to understanding and capacity to apply what has been taught. **ANGIE WALKTHROUGH AND POWERPOINT** Training and practice will be part of Team Meeting agendas and will also form part of Supervision discussions.	**Sessions led by Angie P were consistent in content and evaluated by those present.** **Feedback from Angie, along with a focus in Team Meetings and Supervision will ensure increased clarity on the impact on practice and culture in the house.**

Area for Improvement: Requirement 1		
By 30 August 2024, the provider must ensure that all staff have had relevant training. This is to ensure young people receive safe and consistent care.		
High Level Action	**Specific Action**	**Evidence**
1.05 Develop a plan detailing how the service plans to embed a children's rights based approach within its ethos and culture	1.05.1 Staff will take part in a development day which is delivered by the Champions Board looking at embedding a UNCRC approach in the ethos and culture of the House. This will be revisited as often as required, based on feedback from young people and the Champions Board. Additionally, SAC have developed a Child Friendly Complaints Procedure, which will be the approach taken to any complaints raised by our young people.	**Sessions delivered by Dawn along with input from Champions' Board.** **Young people will use the new child friendly complaints process as and when that is needed, and we will seek feedback around whether that is an improvement for them or not.**

Area for Improvement: Requirement 1		
By 30 August 2024, the provider must ensure that all staff have had relevant training. This is to ensure young people receive safe and consistent care.		
High Level Action	**Specific Action**	**Evidence**
1.06 Identify effective and clear strategies to support children and young people.	1.06.1 SMART-er processes in care planning, (Appropriate Language, Communication, written and verbal between staff to staff, and staff to YP, staff to management and vice versa) SMARTER RAs need to be developed to ensure all salient and pertinent information is captured. Keeping safe documents, (Appropriate language to be used) Risk Assessments (RA's) will be written in a manner that ensures all relevant information is contained within, specific issues are addressed and supported and all people, including young people are able to be part of and understand the importance of RAs. RAs will be aligned across the 2 houses to ensure consistency. New RA formats will be developed and in place by 30th August 2024. Risk Assessment meetings to be scheduled within each house on a monthly basis, or earlier in response to a crisis. This will be convened by the house manager or deputised to a senior within the house. Plan for Team Building / Development Day	**Clarity and consistency has been given to Seniors regarding expectations and processes around RAs, Care Planning and the scrutiny of these. The importance of embedding Care Based Language has been reiterated and an information document has been shared to help with this. Revised RAs are now being used and a flowchart for the RA process**

Area for Improvement: Requirement 1		
By 30 August 2024, the provider must ensure that all staff have had relevant training. This is to ensure young people receive safe and consistent care.		
High Level Action	**Specific Action**	**Evidence**
		has been developed and shared. This will be an ongoing and organic process, which will be subject to regular review, to ensure the most effective tool is being used consistently. This area will also be a standing item in Supervision sessions.

Area for Improvement: Requirement 1		
By 30 August 2024, the provider must ensure that all staff have had relevant training. This is to ensure young people receive safe and consistent care.		
High Level Action	**Specific Action**	**Evidence**

Area for Improvement: Requirement 2		
By 30 August 2024, the provider must ensure that there is effective leadership to provide structure and support to the staff team. This is to ensure young people's needs are met and they are kept safe.		
2.01 Ensure there is an experienced manager present within the service to prioritise the needs of the young people.	2.01.1 Ian Scott, House Manager and Martin McAdam, service manager have ensured managerial availability within Cunningham Place every day since Inspection. Ruth Doggart has now returned and will be continuing to ensure this level of presence with support from Ian and Martin. Interim depute manager post for Sundrum View to ensure managerial cover across both houses. Position commenced on 05/08/2024.	**Management availability every day split between Ian Scott, House Manager and Martin McAdam, Service Manager – commenced 15th July 2024**

Area for Improvement: Requirement 2		
By 30 August 2024, the provider must ensure that there is effective leadership to provide structure and support to the staff team. This is to ensure young people's needs are met and they are kept safe.		
2.02 Develop and implement the service's improvement plan to address the culture within the service to create a supportive and open learning culture within the team.	2.01.2 This is ongoing to be developed between senior management, service manager and registered house managers.	**Senior Manager has met with the team and then written to them all outlining expectations and standards required.** **An Improvement Plan has been written and will be added to as progress is made.**
2.03 Ensure that staff benefit from regular advice and guidance.	2.03.1 Supervision dates and Team Meetings have been set 6 months in advance and these will be logged on CareFirst. Team Meetings will be minuted and minutes stored by Business Support.	**Dates have been set and communicatio n with staff that supervision is a priority.** **Templates for Supervision and Team meetings have been updated**

Area for Improvement: Requirement 2		
By 30 August 2024, the provider must ensure that there is effective leadership to provide structure and support to the staff team. This is to ensure young people's needs are met and they are kept safe.		
		to ensure important areas aren't missed and minutes of meetings will be shared.
2.04 Ensure that information is shared effectively within the team.	2.04.1 Team Meeting dates set and staff aware. Meetings scheduled fortnightly. Regular standing items regarding practice in the House, as well as Corporate communications and opportunities for staff to raise any issues, concerns or points for celebration.	**HSCP and other information emails are shared with the team at team meetings and standards and expectations around professional practice in communicatio n have been laid out to the team by the**

Area for Improvement: Requirement 2		
By 30 August 2024, the provider must ensure that there is effective leadership to provide structure and support to the staff team. This is to ensure young people's needs are met and they are kept safe.		
		Senior Manager.
	2.04.1 New changeover sheets have now been implemented with managers and the service manager having access to information regarding young people, daily.	**A new changeover sheet has been developed and distributed to staff and is now in use.**

Area for Improvement: Requirement 2		
By 30 August 2024, the provider must ensure that there is effective leadership to provide structure and support to the staff team. This is to ensure young people's needs are met and they are kept safe.		
2.05 Ensure that incident recording includes important detail and is accurately recorded.	2.05.1 Significant event forms to be checked and commented on by manager. This is to ensure the report is accurate and complete and the actions taken were based on good practice. This also ensures that the manager has an overview of the event/incident. Significant Events are completed in house, they are recorded, printed off as hard copies and stored within the YP file. Seniors or Manager will add narrative to Sig Event form, to ensure managerial oversight. Evidence is QA by House Manager and Service Manager prior to sending SI Notifications. 01/08/2024. CI confirmation that access is granted for QA to start for allocated service and house managers. Email sent out on 01/08/2024 to inform of new notifications process.	**New proformas have been developed and communicated to staff.**
2.06 Ensure that staff are debriefed following an incident to support staff to reflect on their practice and how to best support the young people.	2.06.1 Both Houses must look at how the debrief process is carried out. This is in terms of 'Hot debrief' and 'Cold debrief', (In time debrief and later on reflective debrief). New approach has been designed, agreed and shared with staff.	**New debrief process and templates have been developed and shared. Debrief will also form part of the Team Meeting agenda where appropriate as**

Area for Improvement: Requirement 2		
By 30 August 2024, the provider must ensure that there is effective leadership to provide structure and support to the staff team. This is to ensure young people's needs are met and they are kept safe.		
		well as Supervision sessions.

Area for Improvement: Requirement 2		
By 30 August 2024, the provider must ensure that there is effective leadership to provide structure and support to the staff team. This is to ensure young people's needs are met and they are kept safe.		
2.07 Ensure that staff receive regular and effective supervision to reflect on their practice and identify areas of practice for further development.	2.07.1 Service Manager to oversee supervision with seniors in the interim period. This will be documented and logged on Carefirst. Ian to carry out informal supervision in the form of catch ups. Seniors to supervise their relevant staff and log on CareFirst. Dates for the next 12 months to be put in diary. Informal supervisions to be recorded. Supervision frequency and quality audited quarterly by Practice Improvement and reported to SW Governance Board.	**Supervision dates have been sent out and agreed. New Supervision Template has been circulated and is in use. Quantity and quality is audited externally, quarterly.**

Area for Improvement: Requirement 2		
By 30 August 2024, the provider must ensure that there is effective leadership to provide structure and support to the staff team. This is to ensure young people's needs are met and they are kept safe.		

Area for Improvement: Requirement 3		
With immediate effect, the provider must ensure that to support effective scrutiny of the service, notifications are submitted in accordance with guidance, and that sufficient detail is added to accurately reflect the incident and provide assurance to the Care Inspectorate that the service is responding appropriately.		
3.01 With immediate effect, the provider must ensure that to support effective scrutiny of the service, notifications are submitted in accordance with guidance, and that sufficient detail is added to accurately reflect the incident and provide assurance to the Care Inspectorate that the service is responding appropriately. This is to comply with Regulation 4(1)(a) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SS1 2011/210). This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'I experience high quality care and support based on relevant evidence, guidance and best practice' (HSCS 4.11).	3.01.1 Notification training provided to seniors on 16/07/2024. Notifications will be quality assured by House Manager or Service Manager, prior to submission to Care Inspectorate. This is to ensure appropriate information is submitted. Managerial oversight will ensure consistency.	**Notification training delivered to all Seniors and revised paperwork has been implemented. QA will be applied to every submission by Service Manager or House Manager.**

Area for Improvement: Requirement 3		
This is to ensure that practice is consistent with Records that all registered children and young people's care services must keep and guidance on notification reporting (Care Inspectorate, January 2022).	2.08.2 Handouts to be provided to seniors for reference. Handouts were sent on 18/07/2024.	
	2.08.3 Going forward, managers and service manager will review the notifications that have been posted and a further narrative and update given by them. RA will be reviewed and updated following any notification incident. A skills and registration audit is now completed, and we have established that 100% of the teams are fully qualified and SSSC registered. An interim measure has been introduced whereby any new notifications written by seniors will be quality assured by manager or service manager prior to submission to the Care Inspectorate.	**RA process and paperwork agreed and circulated. Expectations and standards were communicated to Staff.**

Area for Improvement: Requirement 4		
By 30 August 2024, the provider must ensure that there is the correct number of suitably qualified and competent staff on shift. This is in order to comply with section 7 of the Health and Care (Staffing) (Scotland) Act 2019. This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'My needs are met by the right number of people' (HSCS 3.15).		
4.01	4.01.1 Qualification, skills and training audit will be carried out to explore the training needs of staff. 100% of staff fully qualified (SVQ3 and HNC for residential staff or SVQ4 for senior staff). Admin staff record information and access to training log.	**Spreadsheet database of all staff with qualifications and training is now held with Admin and will be regularly reviewed by House Manager and Service Manager.**

Area for Improvement: Requirement 4		
By 30 August 2024, the provider must ensure that there is the correct number of suitably qualified and competent staff on shift. This is in order to comply with section 7 of the Health and Care (Staffing) (Scotland) Act 2019. This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'My needs are met by the right number of people' (HSCS 3.15).		
	4.01.2 Night shift numbers and gender make up to be looked at and changes made. This will also spread the load over the two-night shift teams and reduce the impact on days. Night shift teams have been changed over as of week beginning 29/07/2024 Change of shift team and gender equality in place.	**Night shift teams were changed in response to issues raised. New rota was circulated.**

Area for Improvement 1		
To promote high quality care and support for all young people within a culture of continuous improvement, the provider should ensure that robust quality assurance processes are in place to promote improved outcomes for young people. This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'I benefit from a culture of continuous improvement, with the organisation having robust and transparent quality assurance processes' (HSCS 4.19).		
High Level Action	**Specific Action**	**Evidence**
1.01 Continuous Auditing and monitoring of training needs of staff team and logging system Robust Plan of training continuation and quality assurance in applying the training	1.01.1 From September to December 2024, the SM will review training logs weekly. This will move to monthly reviews in January 2025	**SM to review weekly at CP**
	1.01.2 From September to December 2024, the SM will review the QA process with training partners. SM to have monthly contact with training partners. Reviews will become quarterly from January 2025	**Dates and review information**
	1.01.3 Quality Assurance tool updates from YP and Staff	**Information from QA tool**
	1.01.4 Regular Team Meetings. Information sharing, training discussions, In-house events, and cultural views and YP updates.	**Minutes from Tuesday team meetings**

Area for Improvement 2		
Previous area for improvement 1 In order to ensure young people, have the service that is right for them, the provider should ensure that decisions about admissions are fully informed by a robust, clearly evidenced assessment and matching process. This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS), which state that: 'My care and support meets my needs and is right for' **Action taken since then.** The service supported young people's transitions to and from Cunningham Place, this included convening consideration meetings to ensure young people's support was planned. It was pleasing to see that the service had developed impact assessments since the last inspection, however these had not yet been implemented in practice. Not all elements of this have been met. **This area for improvement has not been met.**		
High Level Action	**Specific Action**	**Evidence**
2.01 Robust Considerations meeting process is in place. Evidence of this to be made available to the CI. Impact assessment paperwork to be used for all new young people coming into Cunningham Place.	2.01.1 Considerations meeting will take place with relevant partners with robust exploration and action notes and decisions taken from meeting available	**Action Note / Minute**
	2.01.2 Impact Assessments will be undertaken for all new arrivals and existing young people living at CP	**Impact Assessment Paperwork**
	2.01.3 Weekly review of Briefs and De-briefs by SM. Information relating to B&DBs will be provided through the team meeting template agenda	**Team meeting minutes** **Supervision**