

Potterspurty Lodge School

Potterspurty Lodge, Towcester, Northamptonshire NN12 7LL

Residential provision inspected under the social care common inspection framework

Information about this residential special school

Potterspurty Lodge School is an independent residential special school for 49 young people aged eight to 19 years. The school offers termly and weekly boarding, as well as day provision.

The school is situated in south Northamptonshire and caters for children with autism spectrum disorders, complex needs and challenging behaviour.

Inspection dates: 6 to 8 February 2019

Overall experiences and progress of children and young people, taking into account **requires improvement to be good**

How well children and young people are helped and protected **requires improvement to be good**

The effectiveness of leaders and managers **requires improvement to be good**

The residential special school is not yet delivering good help and care for children and young people. However, there are no serious or widespread failures that result in their welfare not being safeguarded or promoted.

Date of previous inspection: 13 March 2018

Overall judgement at last inspection: inadequate

Key findings from this inspection

This residential special school requires improvement to be good because:

- Young people's welfare is not always fully protected. Although there has been improvement since the last inspection, there has been a recent cluster of significant events which have not been managed well by staff.
- There has been a high turnover of staff. There is a group of consistent core staff who know how to meet young people's needs, but there are a lot of new staff whose skills are still being developed.
- Young people have not received consistent care because of staff changes.
- Managers have started to make improvements and the school is going in the right direction, but not all the required changes have taken place.
- Some records do not meet the required standard. For example, one significant event was not recorded properly. Another example is that one young person's daily diaries are difficult to follow. It is difficult for leaders to gain a clear picture of what has happened and when. When investigations take place following incidents, these are not recorded. The action taken is not clear and there is the potential for managers to miss something.
- Not all staff have received safeguarding training in relation to how young people can be lured into carrying drugs across the country, known as 'county lines'.

The residential special school's strengths are:

- The organisation has provided additional scrutiny, which has identified weaknesses and areas for improvement. All managers are very clear about the improvements needed.
- Leaders now supervise individual shifts. They know when safeguarding incidents have happened. They support staff to improve their practice and there is a stronger management presence on each shift.
- Staff feel that there have been significant positive changes. One member of staff said: 'It is 100% better.'
- The organisation is committed to only admitting more children when they feel that there has been sufficient positive change. This is to ensure young people's safety and well-being. Maintaining the current number of seven children will allow for improvements to be 'bedded in' during this period. This is a very positive commitment, given that there are 26 residence places.
- The new head of care and the deputy head of care have been instrumental in improving management support on individual shifts. Staff are receiving the support and mentoring they require to improve their practice.

- Placing authorities are happy with how the school is developing and there have been some very positive comments.
- Young people feel safe.

What does the residential special school need to do to improve?

Compliance with the national minimum standards for residential special schools

The school does not meet the following national minimum standards for residential special schools:

- Ensure that there is continuity of staff such that children's relationships are not overly disrupted. (National Minimum Standard 15.7)
- Ensure that every child has an accurate, permanent record of their history and progress, which can be read by the child at any time (except where the data controller is not obliged to supply the information to the child) and add personal statements or statements correcting errors. (National Minimum Standard 22.1)
This is in relation to records of significant events, young people's daily diaries, care plans, risk assessments and other documentation pertaining to children.
- Ensure that arrangements are made to safeguard and promote the welfare of children at the school. (National Minimum Standard 11.1)

Recommendations

- Ensure that there is a full, well co-ordinated and recorded investigation after incidents and where concerns are raised about staffs' practice. (Linked to National Minimum Standard 20.2)
- Consider providing staff with further training about how young people can be lured into carrying drugs, known as 'county lines'. (Linked to National Minimum Standard 19.1)

Inspection judgements

Overall experiences and progress of children and young people: requires improvement to be good

Young people's experiences are not consistently good. Improvement is noted, but young people are being looked after by a lot of new staff, some who are inexperienced. Young people do not experience consistency from staff. This impairs their progress. Some staff are making mistakes in their practice, leading to incidents.

When leaders decided that a young person could not be at school due to the complexity of their behaviour and for safety reasons, the parents were left feeling confused due to a lack of information. The young person's social worker also felt that during this period, communication was not clear. However, this professional also noted considerable improvement in communication between the school and the parents more recently, so this is an improving area.

Young people have access to a range of positive experiences. They try out new and exciting activities for the first time. There are enough staff to take them to activities in the community, such as trampolining and cadets. Young people and parents made some positive comments about the residential provision. Professionals were also very positive. Their comments included: 'It is the best move I have made for [the child]' and 'It's work in progress; they are getting there'.

Young people have made good progress in developing more positive relationships with staff. Young people have also made progress in education. The reward incentive scheme is working well to encourage young people to make progress. There is consistency between education and care staff and both work together to maximise progress.

Young people's health is a priority. They receive their prescribed medication from trained staff. Lessons have been learned from a recent error in giving a young person the wrong amount of medication. First aid is readily available from trained staff who are always on duty. Mental health also has a high priority. A mental health nurse has been appointed since the last inspection. Their expertise is used during incidents. They have a presence in the residential setting and there are regular discussions with staff about how they can support young people with their mental health needs. The emphasis on mental health is increasing and the recent introduction of mental health first aiders further supports this work.

Several records fell short of the required standard. For example, one significant event was not properly recorded. Another example was that young people's daily diaries contain loose-leaf pages which are not easy to follow and could easily become out of order. Care plans are not presented in a uniform way for staff to get used to and understand. Also, risk assessments do not always set out information very clearly. If this is not put right, it may hinder the pace of development.

How well children and young people are helped and protected: requires improvement to be good

Safeguarding incidents are reducing overall. There has been a cluster of significant incidents more recently, which have put staff and young people at risk. However, the improved leadership presence on each shift ensures that senior staff quickly realise when young people are unsafe. They develop action plans to continue to monitor young people's safety very closely. Young people are therefore better protected. Professionals confirmed that safeguarding procedures have been followed.

The high turnover of staff means that a lot of staff are still developing their skills. Some have made mistakes which have had an impact on young people's safety. This is improving. The deployment of staff on individual shifts seeks to share the expertise as much as possible. Agency staff only work with a more experienced staff member.

Behaviour management is a developing area. Some young people's behaviour becomes very challenging for new staff. However, new staff are growing in confidence. It is very clear that young people are only restrained where they present a risk to their own, or someone else's, safety or well-being.

Core staff know young people well. Young people feel able to tell them about their concerns and worries. There is always a trusted adult for young people to talk to.

Recruitment is thorough. Safe recruitment checks are carried out for agency staff. This reduces the risk of unsuitable staff working with the young people. The head of care and the deputy head of care add an additional layer of scrutiny to this process.

The reporting of significant issues or events has improved since the last inspection. There is a much clearer idea of what is happening in the residential setting. The quality of documentation pertaining to incidents is not always of a good enough quality. It falls short of the required standard because it does not tell the story of the event. This makes it more difficult for leaders and other professionals to analyse safeguarding practice to ensure that it is effective.

The effectiveness of leaders and managers: requires improvement to be good

Progress in improving leadership and management has been slow. However, the momentum has recently improved. The school head is now supported by a newly appointed director of education. Leaders are now bringing about the required changes. Developments include greater management oversight of each shift. This is achieved through a newly appointed head of care and deputy head of care. Staff now feel that they can rely on a manager to be there for support. Staff spoke very positively about leaders and managers. They have significantly improved confidence in the managers and this has started to influence improvement.

When practice is scrutinised, and shortfalls are identified, there is a good

management response. However, records do not show that investigations are as thorough as they should be. The lack of clear documentation does not support the monitoring and evaluation of incidents and what improvements are required.

Governors and senior leaders are realistic about the school's current position. They have a realistic approach to the work required. They have learned lessons from the shortfalls identified at the last inspection, and recognise that there was not as much challenge as there should have been from governors and senior managers. The organisation has a real commitment to improvement now. They do not have plans to admit any more young people until they feel that the required changes have been sufficiently embedded.

One significant incident has been missed during routine scrutiny by the independent visitor because it had not been properly recorded. However, this is an isolated incident. The visitor has scrutinised the quality of care to young people and reported on these visits to the senior leadership team.

Staff recruitment continues. Staff feel well supported and they receive training to do their job effectively. Training has improved and now contains guidance to staff on how to support young people with regards to any sexually harmful behaviour and how to protect young people when they are on the internet. Staff have not yet received training on how young people can be lured into carrying drugs. They do not fully understand how young people can be groomed to become involved in this.

There has been significant improvement in making sure that the required standards for residential special schools are met. Out of the 10 recommendations made at the last inspection, nine have been met. This demonstrates the organisation's commitment to improvement. There have been improvements to protecting young people, although this standard is not yet fully met. There have been improvements to health and safety, risk assessments, care planning, admissions, and children missing from care procedures. Ongoing recruitment has ensured that there are sufficient staff, but there is a long way to go before all are sufficiently skilled to meet the needs of the young people.

Information about this inspection

Inspectors have looked closely at the experiences and progress of children and young people. Inspectors considered the quality of work and the differences made to the lives of children and young people. They watched how professional staff work with children and young people and each other and discussed the effectiveness of help and care provided. Wherever possible, they talked to children and young people and their families. In addition, the inspectors have tried to understand what the school knows about how well it is performing, how well it is doing and what difference it is making for the children and young people whom it is trying to help, protect and look after.

Using the 'Social care common inspection framework', this inspection was carried out

under the Children Act 1989 to assess the effectiveness of the service, how it meets the core functions of the service as set out in legislation, and to consider how well it complies with the national minimum standards.

Residential special school details

Social care unique reference number: SC012962

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Inspector(s)

Caroline Brailsford, social care inspector (lead)
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