Oakhill Secure Training Centre

Chalgrove Field
Oakhill
Milton Keynes
MK5 6AJ

Full inspection

Inspected under the secure training centres joint inspection framework

Information about this secure training centre

Oakhill Secure Training Centre is operated by G4S Care and Justice Services. The centre provides accommodation for up to 80 children, male and female, aged 12 to 19 years, who are serving a custodial sentence or who are remanded to custody by the courts. There were 66 children resident at the STC at the time of this inspection: 59 boys and 7 girls.

Education is provided on site in dedicated facilities by G4S. Healthcare services are provided by Dr PA. The commissioning of health services at this centre is the statutory responsibility of NHS England under the Health and Social Care Act 2012.

Inspection dates: 21 to 25 July 2025

Overall experiences and progress of children and young people, including judgements on:	**inadequate**
Children's education and learning	requires improvement to be good
Children's health	inadequate
Taking into account:	
How well children and young people are helped and protected	inadequate
The effectiveness of leaders and managers	inadequate

Dates of the last inspection: 21 to 25 October 2024

Judgement at the last inspection: inadequate

Recent inspection history

Inspection date	Inspection type	Inspection judgement
February 2025	Assurance	No judgement
December 2024	Monitoring	No judgement
October 2024	Full	Inadequate
March 2024	Assurance	No judgement

Inspection judgements

Overall experiences and progress of children and young people: inadequate

1. Due to the serious concerns found at this inspection, the Chief Inspectors of Ofsted, His Majesty's Inspectorate of Prisons and the Care Quality Commission invoked the Urgent Notification Protocol and have written a public letter to the Secretary of State for Justice.

2. There are very serious and systemic failures at Oakhill Secure Training Centre (STC) that mean children have been and remain at risk of harm. Safeguarding systems are in disarray, with delays by centre staff in notifying the internal safeguarding team of concerns, leaders' failure to report serious matters to human resources, and/or delays in alerting local authority children's services and the local authority designated officer (LADO). At the time of this inspection, it is unclear how many children have been at risk or harmed. The local safeguarding partnership will need to consider leading a review of safeguarding at the centre in collaboration with the Youth Custody Service (YCS) and G4S.

3. Leadership has failed, and in the last few weeks has fractured. The centre's director and one of the two deputy directors have been suspended, with the other deputy director having been dismissed. A new interim director and deputy director have been appointed, but had only been in post a matter of days at the time of this inspection. As a result, they have had very limited opportunity to have any meaningful impact, though they have started the journey of understanding the issues and are taking action.

4. Staff conduct is of significant concern. There have been a number of suspensions relating to allegations about staff behaviour with children.

5. Some children continue to be separated from other children for extended periods inappropriately, and the healthcare that children receive continues to be poor.

6. Plans to help support children and to track their progress continue to vary in quality and have not improved since the last inspection. There are too many different plans for each child and these are inconsistently and/or not appropriately located around the centre, which means they are not always easily accessible by all staff. As a result, staff do not always have a holistic understanding of children's needs to ensure that they provide safe and effective care.

7. Too few interventions are being delivered for children to address the reasons why they are in custody, which is one of the primary functions of an STC. The forensic psychology team has been understaffed and has not focused its resource to ensure that children are supported to address their offending behaviour prior to leaving the centre. This was an area for improvement at the last inspection.

8. Some of the children are living in unsanitary conditions. Children's living environments vary in their cleanliness and are hot and stuffy. Children told inspectors that they do their best to keep their rooms clean. Some communal areas, such as kitchens and carpets, are very dirty.

9. The main kitchen is unhygienic. The floors, backs of doors and staff areas are in a poor state. Food is therefore being prepared in an environment that could negatively impact on children's health.

10. Meals provided to children are suitably varied, but most children said they did not have enough to eat. Mealtimes are too close together, and the inadequate weekly additional supplies provided by the kitchen to each unit are not sufficient to prevent children from feeling hungry later in the evening.

11. At the time of this inspection, children had not had their hair cared for or cut for some time. Inspectors could see that some children's hair was falling out or their plaits becoming matted. The interim director took immediate action to resolve this.

12. Children are being inappropriately charged from their pocket money to contribute towards charities under the umbrella of a victim fund. For those children on remand, this implies that they are guilty of the alleged offence. Children's money was not going into the official government victim surcharge fund, but being redirected to the provider's account and then to selected charities without children's agreement. Although the interim director stopped this practice immediately when raised by inspectors, there is more to do in considering how monies taken from children can be identified and reconciled.

13. Most children said they have a member of staff that they can turn to if they have concerns and that staff listen to them and help. These trusting relationships are undermined by the behaviour of other staff. Children told inspectors that sensitive information, such as children's offence details or private information about staff, is frequently shared by some staff members with other children. This could place children at risk and compromise adults working at the centre.

14. Some staff refer to children as 'trainees', and children are also now starting to refer to themselves as trainees, which undermines a child-centred culture.

15. Most children are frequently bored. Since the last inspection, the number of activities available has reduced and is limited. Children spend too long milling around on the units in the evenings with very little to do. Board games and soft furnishings have very recently been provided following the new interim director taking up post. Children questioned the intention behind the sudden delivery of these new items as it coincided with the start of this inspection, and children felt that this was disrespectful.

16. Children's complaints have been mainly about their belongings and have been relatively low level. Responses to these complaints have improved since the last

inspection. The complaints process has been reviewed, investigations are now thorough, children's views are sought, and robust quality assurance practices are embedded. Children receive a timely response that fully addresses the concerns they have raised.

17. Youth council meetings are taking place but are ineffective. There is inadequate representation of children across all units. Key senior leaders who can act on children's views and wishes and then effect change do not always attend, and issues raised by children often go unaddressed. When suggestions from children have been agreed, it takes too long to implement them.

18. Children have regular access to Barnardo's (independent advocacy service). Advocates support children with matters related to transitioning both in and out of the STC and listening to and escalating complaints. There is also a chaplaincy team that delivers a range of services, such as faith groups and bereavement support. The advocacy service and chaplaincy teams have failed to identify or escalate concerns about children's living units or about staffing levels.

19. The family support worker helps children to have regular and meaningful contact with people who are important to them. Feedback from children and families is that designated family days are enjoyable and engaging. Activities delivered are thoughtful and appropriate. This is helping children to maintain relationships with their loved ones.

20. Routine visits that children receive from their families have been negatively impacted. Due to lack of availability of staff to take children to visits, children do not have their full allocated time. In one example shared with inspectors, a child was 45 minutes late to their visit due to staff shortages. Their visit was curtailed to 15 minutes rather than the usual 60 minutes, with no time extension offered. Some families travel long distances. This inability of the centre to ensure that children and families spend their allocated time together is significantly upsetting for them.

21. Children's transitions to the community are negatively impacted by delays by responsible authorities in confirming where children will live and where they will continue their education upon their release. While the centre appropriately challenges the authorities when suitable plans are not in place, some children still do not always receive a well-planned transition and are left feeling anxious about their futures.

Children's education and learning: requires improvement to be good

22. Since the last inspection, leaders have started to improve the arrangements for the education that children receive. They have appointed new teachers, and they have improved the teaching of English, including the opportunities for children to read. They have rightly identified the need to further develop the sharing of information about children and the need to expand the curriculum, including at higher levels.

However, at the time of this inspection, it is too early to see the impact of improvements.

23. Most education staff have the necessary knowledge and skills to work effectively and sensitively with children. All academic staff hold teaching qualifications, and vocational tutors hold assessor and basic certificates.

24. Most teachers have recently started to use information gathered about children's starting points to plan for children's learning. This information is used to assess mathematics and English levels and indicates what children need to be working towards.

25. Children's aspirations and goals are not used well enough to shape their individual learning plans; therefore, it is unclear what staff are preparing them for. Some children do not receive external accreditation for their learning in vocational subjects, which limits their opportunities on release.

26. Children have access to a limited curriculum delivered at a very basic level in four separate pathways: construction, service industries, music and sport. Children who have previously achieved in mathematics and English can complete independent extended learning but without the full resources needed to be successful, such as access to the internet. Younger children do not get access to many of the national curriculum subjects, such as sciences, humanities or languages. For more academically able children, there is very limited provision to enable them to achieve their full potential. For example, A-level subjects are extremely limited.

27. Most teachers teach the curriculum well. Teachers use different techniques to help children develop their knowledge. For example, in hair and beauty, they discuss the theory of treatments before practising techniques. A few newly appointed vocational staff need help and support to be able to plan and structure their lessons.

28. In lessons, teachers regularly provide children with written and verbal feedback, praising children for what they have done well and identifying what they need to do to improve.

29. There are a number of children with education, health and care plans and many more who have undiagnosed needs. They are not benefiting from dedicated in-class support to keep them on task or to help them make the progress they are capable of.

30. While most teaching staff liaise regularly with residential staff and parents and carers to share the progress that children are making, the information provided is very generic and does not focus specifically on what children have been working on or what children need to do to achieve their aspirations.

31. Most children learn new knowledge and skills. In mathematics and English, children often move up at least one level. Children develop their knowledge of the vocational areas they study. For example, in hospitality, children learn to follow recipes and create food they are proud of. In design technology, they learn basic woodwork techniques, which enables them to make gifts for family members.

32. Most children value their education. They are encouraged to engage as part of the incentive scheme. They speak positively about the support and kindness of teachers and participate enthusiastically in education and related learning activities. They enjoy the sport pathway and gain a better understanding of muscle groups and what constitutes an effective exercise programme.

33. Teachers understand children's experiences and put in place appropriate boundaries, agreeing class rules at the start of a 14-week pathway. Most staff support children to develop their social skills and to manage their feelings safely.

34. Children's attendance to education is generally positive. Absences of about 20% are due to legal meetings, visits to the community and medical appointments. The vast majority of children talk positively about how well they attend lessons now compared with when they were in the community.

35. When children are educated out of classes, the learning offer is poor and does not enable children to participate appropriately well in learning. There are too few education staff to enable children to benefit from the teaching they require when teaching takes place other than in education provision.

Children's health: inadequate

36. There are serious and systemic failings in healthcare provision, placing children at significant risk. This has led to an action plan request (see Appendix 1). A new provider began delivery of health services at the centre on 1 May 2025. While the head of healthcare demonstrates strong individual performance, including making some positive improvements, the scale and complexity of the service mean there is insufficient leadership capacity to support delivery and the improvements required. Due to the volume of work held by one person, the head of healthcare is not able to be fully sighted on many risks that inspectors identified. Children are therefore not supported by a healthcare department that has the capacity to meet their needs.

37. Governance structures are poor. Key processes are missing, newly implemented or not embedded into practice. Audits are either ineffective or not completed for essential safe practice areas. For example, medication stocks do not match the records kept. In addition, where audits have been carried out, these are incomplete and inaccurate.

38. Not enough is being done to protect children from known risks to their health. For example, one child has a severe nut and shellfish allergy. Not all visitors were informed of the risks or told not to bring nuts into the centre. Historic information states that the child may suffer seizures when experiencing an allergic reaction. This information was not confirmed by healthcare staff and therefore not included in the risk assessment and treatment plan.

39. Children do not always receive continuity of mental healthcare. Attempts to liaise with community mental health services to understand children's ongoing treatment needs on admission to the centre are not always made. For one child, this was despite the community mental health worker contacting the centre on two occasions.

40. Children with known mental health concerns do not always receive timely care. A child with multiple complex mental health diagnoses was not seen by a mental health professional for 12 days following admission to the centre. For another child, a referral was made to the mental health service with reported suicidal ideation, yet no mental health support was offered for eight days.

41. Not all children are administered medicines safely. One child was given two medicines that should not be prescribed simultaneously as they are known to increase the risk of harmful side effects. Health staff failed to identify the potential for harm and no information has been included in the child's care records to highlight these potential risks.

42. Children do not always receive their prescribed medicines promptly. There is no on-site prescriber. Healthcare professionals, therefore, have to communicate with multiple parties to facilitate a prescriber's request. The process for ensuring that children are prescribed the medicines they need on arrival to the centre is poor. Recorded stocks of medicines do not reflect the actual supply available. This means children do not receive medicines that they need when they need them to keep them healthy and well.

43. Children's physical health concerns are not always quickly investigated, leading to delays in diagnosis and any required treatment. For example, a child had worrying health symptoms and required a sample sending for laboratory analysis. The test had not been processed by centre health staff for over three months. In addition, samples are not safely stored as there is no separate specimen fridge. One sample was found in a medicines fridge.

44. Key health information is not shared between healthcare departments and operational staff to ensure that children receive appropriate care. There is no effective multidisciplinary approach to healthcare interventions to support children. For example, one child was displaying behaviours indicating mental health and language difficulties. The child had been seen by mental health staff and a speech

and language therapist, but none of the recommendations had been shared with operational staff to inform the child's care.

45. Children's clinical records are sometimes inaccurate. There are missing or late entries, meaning that healthcare staff do not have a full understanding of children's care needs.

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

46. There has been a significant deterioration in safeguarding practices at Oakhill. Appropriate actions are not always taken, leading to children being harmed or placed at risk of harm.

47. There are delays in critical information being shared by managers and/or staff with the Oakhill safeguarding team, when there are concerns that a child may be at risk of harm. In addition, cases that meet the threshold for referral to the LADO are not always progressed. When cases are progressed, they are sometimes delayed, with some significant delays of up to seven weeks. This is in the context of statutory guidance that determines that referrals should be made as soon as possible and certainly within 24 hours. This means wider safeguarding mechanisms that help to protect children are not triggered. When there are delays in responses from the LADO, these are not always followed up promptly by the centre safeguarding team.

48. The safeguarding team is not consistent in identifying and responding to serious concerns about children. Managers have not taken appropriate steps about a number of serious allegations regarding staff conduct, including not sharing the concerns with, or collaborating with, the human resources team. In some instances, this has meant that staff have continued working with children when it appears to be inappropriate given the gravity of the allegations made. This leaves children and staff without appropriate safeguards.

49. Safeguarding tracking mechanisms are ineffective. Recording is often chaotic, and it is unclear if all concerns have been fully explored and addressed. While records appear to show that actions have been taken, when inspectors explored these in more detail, it was not clear whether appropriate actions had been taken. This current tracking is providing a false sense of security that children are safeguarded when this is not the case.

50. When physical restraint is used, practice is mostly appropriate and proportionate. Most use of physical restraint is in response to violence, and violent incidents remain frequent. There is effective scrutiny following incidents and reviews identify any concerns and learning. Despite this, follow-up actions are not consistent or timely. This limits the centre's ability to improve staff practice. It potentially compromises the effectiveness of safeguarding arrangements.

51. Some children have experienced unintentional pain during the use of physical restraint by staff. The centre uses inverted wrist holds (wrist flexion). This is an

approved technique under the 'Minimising and Managing Physical Restraint' manual in which staff are trained and is approved and endorsed by government. Wrist flexion can by application alone cause pain to children, which inspectors observed, and children reported. A newer version of this manual that no longer uses this pain-inducing technique is available. However, leaders and staff at the centre have not been provided with training in this version.

52. Some children have been separated for extended periods. The rationale for continuing separation into many days is not always clearly documented and the practice is inappropriate. For these children, oversight and review mechanisms are not sufficiently robust to ensure that children's rights and welfare were consistently prioritised. Leaders cannot be assured that separations ended at the earliest and safest opportunity. The practice of routinely separating children who did not attend education, which was identified at the full inspection in October 2024, has ceased.

53. An incentive scheme supports children to develop positive social skills and behaviour, which children understand and respond to positively. Children report enjoying the rewards available. Girls are disadvantaged by elements of the scheme, as they do not have access to the platinum unit, which provides extra rewards for boys, such as free access to the kitchen. Adaptations have not been made for girls to make rewards equitable.

54. Some staff said that consequences are not always followed through consistently. This means that children receive inconsistent messages and care. Therefore, their behaviour is not always challenged effectively, and expectations are not reinforced reliably.

55. Security arrangements to reduce children's access to illicit items have improved. Physical security improvements and proactive security measures, including links with the police and drug dogs, are now in place.

The effectiveness of leaders and managers: inadequate

56. There is a palpable change in culture across Oakhill since the last inspection. The culture is no longer child centred. A number of staff shared patterns of concerns with inspectors. For example, some staff report that confidential information is leaked across the centre, and others explained that their decisions have been undermined. When this and other worries and concerns have been raised by staff with managers, some staff have been threatened with what they described as 'unauthorised punishments'. Staff convey a culture of fear, mistrust and reprisal if they raise issues.

57. Despite multiple layers of governance and quality assurance mechanisms, these systems are poor and management grip is weak and ineffective across critical areas, leading to serious impact on children's care. Safeguarding processes and mechanisms are not consistently followed by staff and leaders alike, including taking timely assertive action. Leaders have failed to work effectively across

departments and with external key and statutory partners to help keep children safe and protected.

58. Recommendations from the last inspection that seriously impact on the care and experiences of children have not been addressed. Some children continue to be separated inappropriately from their peers for prolonged periods of time. Poor healthcare places children at risk.

59. In the last few weeks, leadership has been in turmoil as set out in paragraph 3 of this report. The new interim director and deputy director had only been in post a matter of days when this inspection commenced. Staff speak highly of the interim director, saying that, in the very short time he has been at Oakhill, he is highly visible, supportive and beginning to instil confidence.

60. The interim director has started to identify decline in some of the core operational aspects of the centre. He has not had much of an opportunity to make any significant headway given his few days in the role and the magnitude of the failings. He does, however, recognise the scale of the failures to safeguard children and an independent review of all safeguarding concerns is being formulated and will be led by local authority children's services. During the inspection, the interim director took immediate assertive action when concerns relating to staff behaviours were identified by the LADO or the inspection team. In addition, he has taken action to tackle some of the deficits identified throughout this inspection.

61. Between November 2024 and up until 13 July 2025, a significant number of staff have been suspended, of which 17 relate to allegations about conduct with children. Some of these investigations remain ongoing and include, or are being led by, police. A number have resulted in various managerial actions, including some dismissals. Since 14 July 2025, seven more staff have been suspended for matters relating to their conduct with children.

62. Regular targeted recruitment for operational staff is ongoing. However, in addition to the suspensions, several staff are currently on sick leave, including as a result of receiving injuries during their duties. This is limiting the number of available staff, leading to those who are not custody officers being deployed from their usual roles to work with the children. This impacts on the quality of care that children receive and the overall operation of the centre.

63. Although formal supervision of operational staff is regular, staff told inspectors they feel unsupported by leaders and managers. They reported that rotas do not reflect the true staffing levels. Some staff have seen their names on rotas as being on duty when they have not been in the centre, while others reported staff leaving work early and this not being reflected. Some staff told inspectors that they have been left on units at times on their own, leaving them feeling unsafe. Some reflected that despite the new interim director only being in post a matter of days,

they have become more hopeful that positive changes will be made and welcome his different approach.

64. There are too many operational and health staff who do not have up-to-date safeguarding training in line with the centre's expectations. While there is tracking, if essential training lapses, this information is not acted on. Education staff do not benefit from a well-thought-out and developed programme of professional development to ensure that their subject knowledge and pedagogical skills are up to date. Mandatory training for health staff is also lacking.

65. Independent monitoring by the YCS has failed to ensure that action is taken by Oakhill leaders so that children are safeguarded and receive good-quality care. Although the YCS reviews all safeguarding concerns, it has had a narrow focus on contractual compliance, and it did not identify all of the serious weaknesses found at this inspection and, importantly, follow them up. The YCS has been aware, for example, of some of the issues relating to the children's environment and the use of extended separations, sometimes raising these with centre leaders, but these issues have not been sufficiently followed up or effective.

66. The service improvement plan is out of date. Actions are not timebound to insert pace, prioritisation or support accountability. Interventions and key working to support children's transitions remain limited. Not all staff are aware of all available plans for children, which remain disjointed. Enrichment activities previously provided by external community resources have dissipated, and the quality of healthcare for children remains inadequate. Daily meetings to hold to account all departments have commenced. It is too soon to see the full impact for children.

What needs to improve:

Recommendations

- Ensure the safeguarding of children by:
  - Reviewing and confirming that the centre's policies and procedures reflect statutory guidance (Working Together to Safeguard Children 2023). That they are understood by all staff and followed, leading to all safeguarding concerns being reported without delay to the internal safeguarding team, shared as appropriate without delay with human resources and with the local authority designated officer (LADO) and/or local authority children's services;
  - ensure regular and accurate tracking is effective and that all actions are completed.
- If children are separated for extended periods, there must be a clear recorded justification for the ongoing use of separation, and when the legal criteria are no longer met the separation must end.

- Cease immediately the use of inverted wrist holds as a method to physically restrain children.
- Improve the quality and impact of health support for children by:
  - ensuring that children's wide-ranging physical and mental health needs are understood and swiftly met;
  - ensuring that all health records are accurate and appropriate information is shared across the centre to inform the care children receive;
  - ensuring that medications are administered safely;
  - ensuring appropriate storage of specimens and samples;
  - ensuring governance systems and structures promote a safe and well-led service for children.
- Establish and maintain a positive and proactive leadership culture. Leaders in all areas of the centre must have sufficient experience, skills, knowledge, credibility, and where appropriate, qualifications for the role they undertake. Leaders should be visible to all staff across the centre, exhibit and set clear expectations of high standards of professional conduct and be role models for all staff at all levels. Governance and quality assurance mechanisms should support all improvement activity and test the effectiveness of new policies and procedures.
- Senior leaders in the Youth Custody Service should undertake a review of the role, responsibilities and experience of the on-site monitors. To be effective, on-site monitors require sufficient experience, skills and knowledge in working with children and understanding their needs to hold the STC to account if it fails to provide good enough standards of care, safety and well-being for children.
- Improve the quality of education by:
  - reviewing the current curriculum so that it meets the needs of all children and its content is broad and ambitious to enable children to learn as much as possible;
  - understanding children's ambitions and goals so they can be appropriately supported, including through accredited programmes;
  - ensuring that children with an education, health and care plan or with undiagnosed learning needs receive dedicated support to help them make the progress they are capable of.
- Improve the oversight of the incentives scheme to ensure it is implemented consistently by all staff and improve the scheme for girls so that they are not disadvantaged.
- Improve the cleanliness of children's units and the main kitchen.
- Review the length of time between children's meals so children are suitably nourished and have adequate portions, and so that supplies to each house unit are appropriate to meet children's needs.
- Review monies taken from children and take action for this to be reconciled.
- Improve the range and breadth of activities for children.

- Ensure that children receive their full visit entitlement with their family and friends.
- Ensure that there is sufficient staffing on units and that rotas accurately reflect this so that staff can appropriately care for children and are not left vulnerable.
- Ensure that all staff have the appropriate up-to-date mandatory training, including in safeguarding children.
- Improve the culture within Oakhill so that it is child centred, and staff understand clear, professional behaviours that are expected, including keeping information confidential about other staff and children. This should extend to all professionals who visit or work with children in Oakhill.

Information about this inspection

Inspectors have looked closely at the experiences and progress of children and young people under the secure training centres inspection framework.

This inspection was carried out in accordance with Rule 43 of the Secure Training Centre Rules 1998 (produced in compliance with Section 47 of the Prison Act 1952, as amended by Section 6(2) of the Criminal Justice and Public Order Act 1994), and Section 80 of the Children Act 1989. His Majesty's Chief Inspector's power to inspect secure training centres is provided by Section 146 of the Education and Inspections Act 2006.

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Secure training centre details

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Appendix I

Care Quality Commission action plan request

Provider
DrPA Secure

Location
Oakhill Secure Training Centre

Location ID
1-22003646258

Regulated activities
Diagnostic and screening procedures and Treatment of disease, disorder or injury

Action we have told the provider to take
This notice shows the regulations that were not being met. The provider must send CQC a report describing what action it is going to take to meet these regulations.

Regulation 12 – Safe care and treatment

1. Care and treatment must be provided in a safe way for service users.

2. Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include:

   (a) assessing the risks to the health and safety of service users of receiving the care or treatment.

   (b) doing all that is reasonably practicable to mitigate any such risks.

   (g) the proper and safe management of medicines.

How the regulation was not being met:

- Children with mental health care needs were not always seen promptly. For example, one child with multiple complex mental health diagnoses was not seen by a mental health professional for 12 days following admission to the centre. In another case, a referral was made to the mental health service with concerns that a child had reported suicidal ideation. No mental health support was offered for 8 days.

- Children's mental health care did not always continue without delay or repetition following admission to the centre. For example, one child was known to community mental health services. No attempts were made to liaise with the community service to understand the child's ongoing treatment needs.

- Children were not always kept safe from harm. For example, treatment plans did not always take account of significant presenting health needs such as allergies. In addition, historic information was not always sought to inform ongoing care.

- Care plans were not always in place to guide staff caring for children with known health conditions. For example, one child had a diagnosis of a rare health condition.

- No assessment or specific care plan was in place to inform staff of the child's needs or how the condition affects them. Furthermore, no contact had been made with community healthcare services to inform the child's care.

- Children were not always safely prescribed medicines. For example, one child was administered two anti-inflammatory medicines concurrently. Prescribers and health staff failed to identify the potential for harm.

- Children did not always receive medicines in good time. For example, one child waited a week to receive their prescribed medicines upon admission to the centre.

- Children's specimen samples were not always tested promptly to prevent delays in diagnosis or treatment. For example, one child required a sample sending for laboratory analyses. The requested test had not been processed for over three months. In addition, samples were not safely stored, one sample was found in a medicine's fridge.

- Key health information was not shared between healthcare departments and operational staff to improve children's care. For example, one child was displaying behaviours indicating mental health and language difficulties. The child had been seen by mental health staff and a speech and language therapist. However, the recommendations had not been shared between healthcare departments and operational staff to better care for the child.

This was in breach of regulation 12(1)(2)(a)(b)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulation 17 - Good governance

1. Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.

2. Without limiting paragraph (1), such systems or processes must enable the registered person to:

b) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services)

c) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity

How the regulation was not being met:

- Systems for prescribing children's medicines were poor. There was no full time prescriber on site. This meant healthcare staff had to communicate with multiple parties to facilitate the prescriber's request. We saw multiple examples of children waiting too long to receive their medicines as outlined in the details of Regulation 12 above. Furthermore, there were more delays found as a result of the poor process for the continuation of prescribed medicines for new arrivals.

- Governance structures were poor. Key processes were missing, newly implemented, or not embedded into practice. For example, there was no system in place to manage immunisations and vaccinations. The provider was unable to tell us and therefore did not know which child required particular vaccinations. In another example, there was no mental health model of care.

- Systems to manage the day to day running of the service were poor. For example, at the time of the inspection there were 265 open tasks on clinical recording system. Many tasks related to key healthcare interventions which had not been completed.

- Audits and checks were either ineffective or not completed for essential areas. In addition, where audits had been completed, we found these to be incomplete and inaccurate. For example, room temperatures were found to be outside of safe range, no action had been taken to address this.

- Incident reporting was poor. At the time of the inspection, staff had only recently started to use systems to report incidents. We found examples of incidents in care records which had not been reported. Therefore, the provider was unaware of the full extent of under reporting and unable to make changes to improve the service.

- Children's clinical records were inaccurate. We found multiple examples of missing or late entries. For example, one child's mental health care records were not updated for over a week following a key intervention.

- Compliance with mandatory training was poor. For example, 55% of healthcare staff had not recently completed safeguarding children training. Furthermore, systems to track staff compliance with training required improvement.

- Oversight of children's physical health concerns required strengthening to ensure they were investigated promptly. We found systems failed to ensure tests were completed, recorded, sent and received in good time as outlined in the details of regulation 12 above.

- Action plans to improve the service were in place, however, did not include all areas of improvement required. In addition, some points in the action plans were inaccurately recorded as complete or missing. For example, the delays in children receiving medicines as outlined above was not included.

- Leadership structures were not sufficiently staffed to meet the needs of the service. Although the head of healthcare was respected by the team and was attempting to meet the demands of their role, a lack of leadership support meant they were too often relied on for other duties. This impacted the day to day running of the service with many of the concerns outlined in regulation 12 above not sighted to the head of healthcare.

This was in breach of regulation 17(1)(2)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.