Inspection of secure training centres

Inspection of Rainsbrook Secure Training Centre

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Overall effectiveness	**Requires improvement**

1. The overall effectiveness of Rainsbrook Secure Training Centre (STC) to meet the needs of young people is unchanged and is judged to **require improvement**.

Areas for improvement

2. In order to improve the quality of practice at Rainsbrook STC the Director should take the following action.

Immediately:

- ensure the room used for searching young people always maximises young people's sense of security and privacy
- improve the quality of senior management oversight of day-to-day practice in the centre; including that the standard of hygiene is acceptable in all residential kitchen units and there is sufficient equipment for all of the young people
- ensure the rewards and sanctions system is properly understood and consistently applied by staff across the centre
- improve the quality and detail of records in relation to the use of force and restraint, ensure records are completed for all incidents
- ensure there is clarity by all staff in relation to what constitutes single separation and that all incidents are recorded
- ensure inhalers are available at all times for young people who need them and that they follow them as they move around the centre
- ensure all young people have effective and focused weekly key work sessions
- promote the use of telephone interpretation services for on-going contact with young people who do not speak English as their first language
- use the available CCTV and body-worn footage, which is already used to monitor and review incidents of restraint, as part of training and learning for all staff to understand indications of likely incidents and share good practice.

Within three months:

- the Youth Justice Board (YJB) should take decisive action to minimise the number of young people who are admitted late to the centre
- enable all young people to meet with a peer mentor as soon as is practicable after their admission
- expand the variety of methods by which young people can keep in contact with their families and increase personal visits for young people
- senior managers should ensure the security intelligence reporting system is fit for purpose. Reports should be confidential, auditable and incorporate mechanisms to ensure that reports are seen and monitored in a timely manner by senior managers
- ensure dignity and full search forms incorporate a system so that they can be cross-referenced where required to security intelligence reports
- increase the availability of space, and reduce the need for escorts, by using space in or near the education department for health care staff to see young people
- ensure System One is launched when the revised system becomes available in July 2016 and used effectively to support positive health outcomes for young people
- strengthen links with the Local Safeguarding Children's Board to improve external oversight of practice, including the use of force and restraint.

Service information

3. Rainsbrook is one of three purpose-built STCs and is situated near Rugby. The centre is managed by G4S and is designed to accommodate up to 87 male and female young people aged 12 to 18 years who meet the criteria for a custodial sentence or who are remanded to a secure setting. Education is provided on site by G4S. Health care is provided by NHS England under a co-commissioning arrangement with the YJB.

About this inspection

4. A full inspection of Rainsbrook STC was completed in February 2015. The inspection found the management of the centre had deteriorated in the previous 12 months. Young people's safety was judged inadequate as significantly more young people felt threatened by other young people than at other centres and there had been a number of incidents of serious misconduct by staff leading to young people suffering degrading treatment. Consequently overall effectiveness of the centre was judged to be inadequate.

5. An inspection completed in September 2015 noted progress in relation to most of the recommendations of the previous inspection; young people's safety had improved and was found to require improvement. The overall effectiveness of the centre was also judged to require improvement. As a result of allegations made about the mistreatment of young people in Medway STC, an additional unannounced inspection was undertaken to scrutinise the arrangements for the safety of young people, managerial oversight and governance and progress against the recommendations of the last inspection. Not all aspects of the inspection framework were considered during this inspection and judgements were not made in relation to the achievement or resettlement of young people.

6. At the start of the inspection 74 young people were resident in the centre, 61 boys and 13 girls. A team of seven inspectors from Ofsted, Her Majesty's Inspectorate of Prisons (HMIP) and the Care Quality Commission (CQC) completed the inspection. Inspectors drew keys and accessed all areas of the centre. The inspection included confidential individual interviews with young people and staff. Inspectors chose a sample of young people and staff and also spoke to any young person who asked to see them. Residential, education, health care, and night staff were all interviewed. A total of 20 young people and 20 staff were spoken to in confidential interviews during this inspection. Many other young people and staff were spoken to informally during the course of the inspection. In addition, inspectors reviewed CCTV footage of 32 incidents of restraint and the accompanying records, and a range of other documentation including serious incident reports, declarations to the YJB, staffing rotas, disciplinary and child protection files.

7. G4S's contract to run Rainsbrook, which was due to end in November 2015, was extended at the request of the commissioner, the YJB, until the 4 May 2016. The centre is in a period of transition between the current and new provider. Work was underway during the inspection to prepare for the handover to the new provider, this included some changes to the fabric of the building as well as painting and decorating. This had some impact on the presentation of the buildings during the inspection. Senior managers from the new provider, MTC Novo, were on-site during the inspection and met with the lead inspector.

8. This inspection was carried out in accordance with Rule 43 of the Secure Training Centres Rules (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), Section 80 of Children Act 1989. Her Majesty's Chief Inspector's power to inspect secure training centres is provided by section 146 of the Education and Inspection Act 2006.

9. Joint inspections involving Ofsted, HMIP and the CQC are permitted under paragraph 7 of Schedule 13 to the Education and Inspection Act 2006. The CQC is also obliged to regulate registered health care providers under the Health and Social Care Act 2008. This enables Ofsted's Chief Inspector to act jointly with other public authorities for the efficient and effective exercise of his functions.

10. All inspections carried out by Ofsted, the CQC and HMIP contribute to the UK's response to its international obligations under the UN Optional Protocol to the Convention against Torture (OPCAT) and other Cruel, Inhuman or Degrading Treatment or Punishment. OPCAT requires that all places of detention are visited regularly by independent bodies – known as the National Preventive Mechanism (NPM) which monitor the treatment of and conditions for detainees. Ofsted, HMIP and the CQC are all members of NPM in the UK.

The safety of young people	**Requires improvement**

11. The centre has well-established admission processes and procedures. Since the last inspection a post-admission review has been introduced. Young people are spoken to by a manager within five days of their arrival. This is a useful opportunity for managers to ensure procedures have been followed, young people feel safe and have settled in. It is the first of newly introduced weekly meetings between the deputy residential managers and the young people living on their units. This encourages regular communication between young people and managers giving the opportunity to share any concerns they may have directly with a manager.

12. Since the last inspection a risk-led approach to searching has been introduced. The level of search is now determined by intelligence or information available. Full searches are the exception and the duty director's authorisation is required. The new searching process is positively focused on promoting the dignity of young people while balancing the need for security and safety.

13. Late arrivals at the centre are a continuing issue which has not improved since the last inspection. A significant number of young people, about a third, arrive after 9pm, with

a small number arriving after midnight. This was the subject of a recommendation at the last inspection. Centre managers continue to report each late arrival to the YJB who commission the transport service. This has, to date, not led to a reduction in the number of young people arriving at the centre late in the evening.

14. A number of young people and staff who spoke with inspectors were concerned about staffing levels. Some examples were given of young people being in the care of a single member of staff while another member dealt with other issues. Pressures on staffing sometimes lead to delays in young people accessing services such as health care or limit their involvement in activities.

15. Processes for staff to report security or other concerns to managers are insufficiently robust. Reports are currently made to duty operational managers (DOMs). Senior managers cannot be assured that every report made reaches them for their consideration. In response to audit findings managers have made adjustments to the security incident reporting (SIR) process. Records now show if a report does not relate to a security matter. Staff are informed if this is the case and helped to understand how to use the process appropriately. Where a security report recommends a search is undertaken records are not cross referenced to search documents. This means managers cannot easily monitor all actions taken. The process of recording and cross referencing was amended during this inspection to address this.

16. Work continues by the interim Director and the senior management team in setting clear expectations of staff behaviour and to develop a positive culture at the centre. Since the last inspection in September 2015 a significant disciplinary matter occurred involving contraband tobacco being brought into the centre for young people by a member of staff. The centre identified concerns and took appropriate decisive action.

17. Child protection matters are referred in a timely manner to the Multi Agency Safeguarding Hub (MASH) or designated officer as appropriate. Records are up to date, detailed and record progress against agreed actions. In the first quarter of 2016, 24 allegations were referred to the designated officer. This is an increase from nine in the same period last year. However most allegations referred in this quarter were dealt with as a consultation by the designated officer. Six allegations met the threshold for a multi-agency investigation. Action planned by managers in relation to one member of staff was amended on the advice of the designated officer and YJB monitor and disciplinary action was instigated.

18. In response to a recommendation from the last inspection records in relation to decision making in disciplinary matters have improved. Records now clearly reflect the decision made. Some records require more detail to show the rationale for decisions made in relation to suspending, removing staff from operational duties or moving them to another part of the centre.

19. The room used for searching young people when first seen by inspectors at the start of the inspection was stark and unwelcoming. Managers stated that the privacy curtain, which was not in place when the room was inspected, had only been removed as the room was being redecorated. However, a young person had been searched in this room while the curtain was not in place. Managers took steps during the inspection to replace the curtain and the ambiance of the room was improved by the redecoration.

20. Handcuffs are only used when young people go out of the centre, for medical appointments, court or in preparation for leaving, if a risk assessment demonstrates they are needed. Records have improved in line with a recommendation made at the last inspection and the rationale for the use of handcuffs is now clearly recorded. A quality assurance process has also been introduced. The head duty operational manager now checks these records to ensure they are of the expected quality.

21. The centre is aware of its responsibilities in relation to the Prevent agenda. Links in place at the last inspection with the police counter-terrorism team continue. Multi-disciplinary meetings are held when needed to share information. Since the last inspection awareness training has been rolled out to care staff and all staff groups have now received training in this area.

Promoting positive behaviour	**Requires improvement**

22. The behaviour of young people is variable. Inspectors saw some very good behaviour from young people and examples of staff de-escalating behaviour well without the need to resort to restraint. However instances of violence and restraint are too frequent.

23. While the rules of the centre are clear they are not consistently applied. In interviews staff and young people reported that behaviour management is undermined by inconsistent application by staff. Inspectors saw a number of examples where young people had items in their room that were not consistent with the level of the incentive scheme they were on. In other cases young people did not have items they were entitled to. This undermines the effectiveness of the system and those staff who apply the scheme consistently.

24. In response to previous recommendations and feedback from young people the centre is piloting a new incentive scheme. It is positive that new arrivals enter this revised scheme at a higher level allowing them to have items they would not previously have

had on admission. This supports young people settling into the centre and provides motivation to maintain good behaviour.

25. Young people said that most staff challenge inappropriate behaviour appropriately however a minority said that some do not implement sanctions properly. For serious matters young people continue to receive loss of privileges for up to 72 hours. In principle, loss of privileges is reviewed after 24 hours and can be amended in response to good behaviour, mediation or remorse. In practice only one house block had amended a sanction during the previous five months. Use of reparation has also fallen since the previous inspection.

26. The centre has been innovative in using sport to bring together young people who otherwise could not mix. Inspectors saw a rugby training session involving 13 boys, nine of whom were on the do not mix list. Similarly a session for girls included a number who would not have been mixing on residential units or in other activities.

27. Overall levels of violence between young people remain similar since the last inspection but the number of assaults on staff has risen. Although most incidents did not result in injuries requiring medical treatment some were more serious. This resulted in five members of staff and three young people requiring hospital treatment in the previous six months.

28. The number of restraints and use of force has increased since the last inspection. An average of 29 incidents each month, compared with 19.2 at the time of the previous inspection. However the number has not risen to the level, 36, seen at the inadequate inspection in February 2015. Nearly 80% of these incidents included the application of minimising and managing physical restraint (MMPR) holds. Records reviewed by inspectors indicated all recorded incidents were spontaneous. This was not the view of inspectors. The opportunity to defuse a potential incident was missed on some occasions. In others it appeared young people may have anticipated the restraint situation preparing for this by wearing layers of clothing including outdoor coats and shoes.

29. Inspectors reviewed documentation, CCTV and body-worn video camera footage (where available) for 32 incidents covering the four weeks prior to the inspection. In the majority of incidents force was used appropriately to prevent injury to young people and staff. Some footage showed poor practice including poor communication with the children involved, misapplication of holds and use of non-approved techniques. We have also found an example of a Serious Injury and Warning Sign that was not documented or responded to. Inspector's view was that where restraint was not applied correctly this was the result of inexperience or lack of confidence from staff rather than the result of malicious intent.

30. The centre has implemented body-worn video cameras and these are used in most incidents, however there are insufficient cameras available to ensure footage of every restraint and in some cases staff do not turn on the camera to record the incident. Senior managers have taken action against some staff where body worn cameras have not been turned on a number of occasions.

31. It is positive that despite dealing with some very challenging behaviour pain inducing techniques continue not to be used.

32. Use of single separation has increased and inspectors saw one example where single separation was used but referred to as time out. It is not therefore possible to be sure that all episodes of single separation are recorded.

The care of young people	**Requires improvement**

33. Useful information about the centre is provided to young people on their arrival and soon after an information pack is sent to their parents/carers. As highlighted in previous inspections, some of the language in the pack for young people is not child friendly. Not all units have a peer mentor to welcome and support new arrivals and a few young people told inspectors they had not met a peer mentor when new to the centre and were not aware of the peer mentor’s role.

34. The physical condition of residential areas of the centre has declined since the previous inspection and shows signs of wear and tear. At the start of the inspection there was some damaged furniture on residential units and graffiti in some bedrooms and in education facilities. Some of the damaged furniture could present both safety and security concerns. Standards of cleanliness have fallen since the previous inspection and provision of basic equipment such as bowls for breakfast is inadequate for the number of young people living on some units. Weekend deep cleaning is not rigorous enough and residential unit kitchens in particular needed more in depth cleaning. Supervision and standards expected need strengthening.

35. Some young people take obvious pride in, and personalise, their own bedrooms and in tidying communal areas and maintaining a decent living environment. Some observation panels in doors were partially or wholly covered over by pieces of paper at different times during the inspection. Young people said they did this for privacy when, for example, showering and removed them afterwards but one that partially obscured the panel asked to be woken up at a particular time which raised the possibility they were inappropriately left in observation panels over-night.

36. As reported at previous inspections, young people are expected to take their turn in domestic chores around their unit, receiving support to ensure they know how to complete these chores. We heard from some young people that they feel ready for independent living on release after gaining experience of chores like washing clothes, cooking and cleaning their rooms and communal areas. Young people can wear their own clothes and have proper access to toiletry items, in room showers and laundry facilities. They have weekly access to a tuck shop at which differing amounts of money can be spent dependent on their rewards level. Some young people prefer to save some money for their release and are learning about money management in the process.

37. The main mechanism for consultation with young people across the centre is monthly Xchange meetings. These continue to be held regularly, and provide an opportunity for young people to raise questions, concerns, requests and ideas with the centre's managers. At recent meetings, not all units have been represented. Minutes of meetings show that items raised by young people are considered and responded to but these minutes are not readily available on all the residential units. Young people are also invited to participate in focus groups or complete surveys for consultation on specific topics.

38. Positive changes have been made in relation to the collection of complaints. Complaints boxes had previously been opened by duty operational managers but this role has recently moved to the resettlement team which increases confidentiality and reduces any risk of staff involved in the complaint collecting them. In another change since the previous inspection, complaints are investigated by one of two managers rather than by a range of managers as was the case previously. These changes aid consistency of investigation and confidentiality. Complaints are generally responded to in a satisfactory manner, although in the sample looked at during the inspection one warranted further investigation. Young people spoken to know how to make complaints and none expressed any worries about the consequences of doing so.

39. Blank complaints forms were not readily available to all young people on their units during the inspection. The same was true of grumbles books which young people can use to raise issues of concern that they do not feel merit a complaint. The centre's own regular audits show that five grumbles were made in January and February 2016 and showed these came from three different units.

40. Senior managers receive regular updates on complaints. This includes statistical data on topics of complaints, units submitting them, the gender, age, disability status, religion and ethnic origin of the young people making complaints. There was no comparison with the composition of the population to enable any disproportionality to be identified. The updated diversity complaints form now covers all protected characteristics. Complaints submitted since the last inspection concerned the use of

inappropriate language related to ethnicity and were dealt with adequately. The management of diversity continues to be a centre wide approach with all departments contributing. Work is coordinated through a monthly diversity meeting which has good attendance from staff across the centre. There is still more work to be done to show how disproportionate outcomes are identified and addressed, although some focused work is being done on the possible over representation of looked after children in use of restraint.

41. Some progress has been made to improve the support available to young people who do not speak English as their first language but further action is needed. Two such young people spoken to during the inspection using telephone interpretation were isolated and said they did not mix with other young people. The planned use of an IT package to assist communication with children with limited English is a positive step, but more use could be made of telephone interpretation services to support young people in their day to day life at the centre.

42. We met one young person who may have been the victim of trafficking and had not been identified as such by the centre. Further enquiries showed that a community based social worker had made the appropriate referral for this young person and their status is under investigation.

43. There is generally a good focus on the individual needs of young people. This has been aided since the last inspection by the introduction of a weekly one to one meeting for each young person with a deputy residential service manager (RSM), the details of which are noted and passed to the head of care for any necessary further action. Information sharing between different areas of the centre remains effective and use is made of electronic case notes to share information on the progress and needs of individual young people.

44. Inspectors undertook a number of private interviews with young people as part of the inspection, as well as speaking informally to most of the young people at some point. Most young people spoken to reported respectful relationships with staff and used words like "helpful", "fair" and "polite" when describing them. We observed generally good interactions and noted the degree of patience for adolescent behaviour shown by some staff. Similarly, we saw good work to de-escalate volatile situations. Exit interviews with young people conducted by the centre sampled during the inspection were almost entirely positive. Young people described feeling safe in the centre, said bullying was rare and were positive about their relationships with staff.

45. Young people are allocated a keyworker from amongst the residential staff group, however some young people spoken to said they did not know who this was. Part of the keyworker role is to work with their allocated young person on a key work pack on a weekly basis. The pack to be used is identified during training planning or remand

management meetings and will link to the offence committed or behaviour or other factors that led to the young person being in custody or not progressing while at the centre. A review of the key work packs has led to several being discarded as no longer meeting a need and a new evaluation process to assess the effectiveness of those remaining is due to start soon. A small sample of packs identified for individual young people to work through showed that they were not all being progressed on a weekly basis.

46. Some new group work sessions have been introduced since the last inspection. These involve an external facilitator and enable young people to explore amongst other things how to avoid offending behaviour and how to build self-esteem. This is a promising initiative but it is too early to judge impact.

47. Young people are now given a copy of their training or remand plan targets and are seen by caseworkers between formal review meetings. Caseworkers remain the first point of contact with families and carers, making initial contact soon after the young person arrives and sending information about the centre. Parents/carers are encouraged to attend review meetings at the centre and participate in planning for their child's future.

48. Young people are able to make a free, private phone call each day to people on their list of approved contacts, and send three letters each week free of charge. Young people whose family live overseas are able to phone them. Incoming calls are allowed at certain times of the day. Young people appreciated having these calls in private in their bedrooms, although a few said it could take a long time for their callers to get through to them. One family who spoke to inspectors described difficulties in getting phone calls to the centre answered. There are no options to maintain contact using more up to date technology for families or carers who cannot visit in person.

49. A weekly visit is available to all sentenced young people and those on remand can have their visits time spread over a greater number of weekly visits if they wish. Length of visits remains dependent on the distance travelled by the visitors, irrespective of any other factors. We have previously described this as inappropriate and remain of this view. Monitoring of young people who do not receive visits is in place and the information used to offer a visit from a volunteer visitor. Engagement visits which take place in a more relaxed environment continue to be used to maintain and improve family ties, to recognise birthdays and as recognition of achievement within the centre.

50. Arrangements for faith observance are unchanged. The centre's chaplain is visible around the site and readily available to any young people who wish to see him. Regular support for the faiths most commonly represented within the centre's population is usually provided and chaplains for other faiths can be secured when

needed. Major religious festivals relevant to the faiths of young people at the centre are celebrated.

The health of young people	**Requires improvement**

51. Healthcare services in Rainsbrook STC had been re-commissioned at the time of the last inspection but it was too soon to be able to note any impact on delivery. The new arrangements have increased the breadth and extent of healthcare delivery, including sexual health, speech and language and psychology services. The primary nursing service, however, was observed as under some strain during this inspection with the manager and a nurse being on sick leave and an additional nurse on compassionate leave. On one morning this left one nurse on call to respond, while juggling other demands, supported by the Mental Health nurse who happened to have a suitable nursing background and was able and willing to help out. There was also an incident during this inspection where nursing staff were not called promptly to respond to an incident in Education.

52. Nevertheless, health professionals continue to understand and respond well to the individual's health needs and feedback is now sought through an 'I want great care' form which is clear, inviting and includes graphics as well as written ratings. Results from these response forms are collated and are made available to staff and young people. Results are also judged against comparators in the criminal justice system and Rainsbrook performs very well in relation to this assessment. Complaints in relation to healthcare delivery are minimal with only four recorded in the last quarter.

53. Medicine management continues to be impressive and efficient even though much of the recording currently remains a manual task. Medication is well reviewed and good efforts are made to minimise its use unless it is clearly necessary. In-possession medication is limited to proprietary creams and lotions while access to inhalers is managed in the residential units. One specific issue, however, was raised during this inspection related to asthma inhalers. Indications are that inhalers often did not follow young people if they moved units and were sometimes not returned to units from Education. Keeping track and maintaining use of individual inhalers is something which needs strengthening so that young people have access to them when needed.

54. Health staff now attend appropriate reviews and other relevant meetings. The new administrator cross-checks information from the centre diary so that reviews can be picked up, as necessary, by the nursing staff. Incident reporting and the reporting of adverse events have been further developed and are now collected through the Datix system. Incidents are reported to G4S each morning and they are collated by the new administrator within healthcare. Information is also now being collected across

healthcare in relation to cancelled appointments, failure to attend and waiting lists. There is no current waiting list to see a GP and the number on the waiting list for dental services has reduced significantly from 23 in January to six in February of this year.

55. Supervision arrangements for health staff are mixed from regular clinical and line management supervision in the case of the pharmacist to limited input for one member of the nursing staff. Mandatory staff training records have been seen and the main gap noted related to raising awareness of the implications of the Mental Capacity Act.

56. Health assessments continue to be carried out in a timely way using appropriate templates although there remains a problem with young people arriving late at night. Basic reception screening is carried out by other STC staff when there is a late admission.

57. Progress on the electronic patient record system is being made. The computers and the test programmes are now in place but their introduction has been reasonably delayed until July to allow time for the updating of System One and to prevent the need for additional training when the new system is in place. Staff training in the new system will take place prior to July 2016 so staff will be able to use the system as soon as it goes live.

58. Since the last inspection some progress has been made in services for young people with sexually harmful behaviour. Funding has been secured to employ two assistant psychologists to carry out this work and the recruitment process is underway.

59. Health staff expressed concern to inspectors that current staffing pressures in the centre are having an impact on young people accessing healthcare. This is compounded by mixing issues where specific young people have to be taken to healthcare separately. Other centre staff confirmed that there are occasions where they cannot promptly facilitate movement to healthcare for young people. The GP has made efforts to facilitate better attendance by starting his clinic at lunchtime. This appears to be having a positive impact. He also makes himself visible to young people on arrival in order to encourage attendance at his clinic.

60. Young people have benefited from new initiatives from the dentist which have included dietary advice and smoking cessation. Inspectors were concerned that the dentist is no longer issued with keys. This leaves her potentially at risk if left alone as she would be unable to leave the building; it also limits her access to the defibrillator. Senior managers addressed this immediately it was brought to their attention during the inspection.

61. Good use is made of a relaxation group run by the mental health nurse with positive outcomes for young people who experience difficulties sleeping. Healthcare workers are positive about the dental input and new initiatives which include dietary advice and smoking cessation. The speech and language therapist is having a positive impact providing some staff training as well working with young people individually.

62. There are good links between the mental health nurse and the substance misuse worker. The substance misuse worker is creative and will carry out group work with all young people in a residential unit reducing the need for young people to be escorted to her. The difficulties of seeing young people, which were highlighted at the last inspection, have eased and there now appears to be much more cooperative working with education staff. Auricular acupuncture is proving to be popular and helpful and is offered two or three times a week. The removal of the worker’s IT link to the G4S system has made it more difficult to access all the information she needs about the young people she is working with.

63. There is limited space for health workers to see young people in their building, particularly when the dentist, psychologist and doctor are present at the same time.

64. Health staff are clear about their responsibilities to report inappropriate behaviour by staff or any issues concerning contraband coming into the centre. They were able to give examples where this had been done and more recently have received feedback on the action taken in response to their concerns.

The effectiveness of leaders and managers	**Requires improvement**

65. Since the last inspection the interim Director of the centre has changed roles in the organisation and the Head of Care has been appointed as interim Director. She is suitably qualified and experienced.

66. G4S’s contract to run Rainsbrook was due to end in November 2015. It was extended, at the request of the commissioner, the YJB, until the 4 May 2016. Regular meetings between the current and new provider, MTC Novo, are in place to assist a smooth handover. Inspectors saw examples of positive co-operation to support this, for example MTC Novo being given access to the site to undertake work needed for a new IT system. G4S has taken steps to ensure those young people due to take examinations, including GCSEs, after the transfer of contract are able to sit them. Young people have been entered, entry fees have been paid and an examination

timetable showing entrants and timing of examinations has been given to the new provider.

67. Communication has been less effective in relation to arrangements for the continuity of staff recruitment. Although agreements were in place between the current and new provider for recruitment to continue these were not successfully implemented. This has meant new staff have not been recruited since February 2016. In recent months an average of eight staff a month have left, rising in one month, to 15. This has put increasing pressure on the management team to ensure there is sufficient and appropriate staffing across the centre. Additional payments have been introduced to encourage staff to work extra hours. Detailed monitoring is in place to ensure excessive hours are not worked and a cap is in place on the number of additional shifts possible in any three-week rota period. Only a small number of staff are working close to this level and their performance is monitored to ensure it is not affected by tiredness. Minimum staffing levels have been maintained, and exceeded, throughout this period. Some staff and young people told inspectors there were times when only one member of staff was on the unit because staff were needed elsewhere. Staffing pressures have also led to staff being moved to work in other units. This has an impact on the ability of young people to develop trusting relationships with the adults caring for them.

68. Senior managers have continued to develop new initiatives despite the contract nearing its end. Young people are now seen by managers five days after their arrival and have weekly one to one sessions with them. New arrangements have very recently been put in place to strengthen the quality assurance processes and a new system is in place to provide feedback to staff on any security reports they make.

69. Senior managers have reinforced staff expectations in relation to their behaviour and guidance has been refreshed. Staff who spoke to inspectors understood their responsibilities and in some cases gave examples of reporting issues and seeing action taken as a result. Where practice was less than good, for example in the application of sanctions and rewards or restraint, inspectors found no evidence that this was malicious or the result of staff favouritism or victimisation of young people.

70. Oversight of day-to-day practice is less good than it was at the last inspection. Senior managers were not aware of some of the shortfalls seen by inspectors during this inspection, for example the standard of cleanliness of some units and the absence of basic equipment in some unit kitchens. Positive practices such as the review of sanctions have lapsed in some units and rewards and sanctions schemes are being applied inconsistently.

71. There are links in place between the centre and the designated officer for allegations and matters are reported to him or the MASH promptly. Oversight by external bodies

of practice in the centre is limited and generally only occurs in relation to specific incidents. This reduces the opportunity for external scrutiny of practice, challenge of poor practice and learning from examples of good practice. This could be strengthened further.

72. Progress has been made in relation to most of the recommendations made at the last inspection. Two recommendations repeated at the last inspection have not yet been fully implemented but funding has been secured for sexually harmful behaviour posts and staff are in the process of being appointed. Equipment for the electronic health recording system is in place, staff are undergoing training and it is expected to go live following the launch of a revised system in July. Progress in relation to the inspection action plan is monitored by the Director and the rag rating applied by her is appropriate.

73. Inspectors found no evidence of the falsification of records but records are not always sufficiently detailed or consistently record all actions taken. In some cases seen actual practice was better than that reflected in the records.

Record of main judgements

Rainsbrook Secure Training Centre	
Overall effectiveness	**Requires improvement**
The safety of young people	**Requires improvement**
Promoting positive behaviour	**Requires improvement**
The care of young people	**Requires improvement**
The health of young people	**Requires improvement**
The resettlement of young people	**Not reviewed at this inspection**
The achievement of young people	**Not reviewed at this inspection**
The effectiveness of leaders and managers	**Requires improvement**