Richmond Fellowship(The)

Trinity Street

Inspection report

27 Trinity Street
Batley Carr
Dewsbury
West Yorkshire
WF17 7JZ

Tel: 01924456160
Website: www.richmondfellowship.org.uk

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection of Trinity Street took place on 1 February 2016 and was unannounced. The service had previously been inspected in July 2013 and was fully compliant with the Health and Social Care Act 2008 and its associated regulations.

Trinity Street provides support and accommodation for up to 12 people with mental health needs. Located in a quiet suburb of Batley it is operated by the Richmond Fellowship, a national charitable organisation. Accommodation is provided on the ground floor of three interlinked bungalows. Each bungalow offers communal use of a kitchen, laundry, lounge, dining room, bath and shower rooms and individual bedrooms for up to four clients. Secure gardens provide a private leisure area.

The service is undergoing a period of change and on the day of inspection only four people were living there as others had been moved on to different accommodation that enabled them to be more independent.

The service has three registered managers, although one is in the process of de-registering. There were two registered managers at the service on the day of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found that people were supported by well trained and informed staff who knew how to safeguard people. Incidents were reported in detail and appropriate analysis followed with scrutiny form senior managers where required. Risk assessments were comprehensive and reflected a person's specific needs.

Staffing levels were appropriate for the service on the day we inspected, especially as two people spent much of the day out of the service. Medicines were administered and stored in line with guidance and people were encouraged to self-administer where they felt able to.

We saw staff received regular supervision allowing them to reflect on their practice and consider areas of their own personal development. This was supported by an annual appraisal where staff and line managers evidenced the fulfilment of agreed objectives and outlined future learning needs.

Consent was sought from people in the service at every opportunity and it was clearly recorded where people had either refused to undertake a particular activity or where they did not wish to give written consent. Staff encouraged people to make decisions in their best interests, especially in regards to visiting GPs or dentists explaining the benefits to people and the consequences of missing such appointments.

People had access to nutritious meals, especially during the evening when they ate together.

Although observation of interactions were limited during the day as people went out into the community,

we saw staff engage with people in a patient and kind manner, clearly knowing people well by the conversations that were held. As everyone in the service had capacity staff provided support sensitively and empathetically to ensure that people felt supported but not overwhelmed. We saw good examples throughout the day as to staff's awareness of the importance of privacy, both in terms of where conversations were held and in the management of personal information.

Care records were written in conjunction with the person and showed their abilities and aspirational goals. These were regularly monitored by weekly meetings with their keyworkers and goals adjusted as required.

Complaints were handled efficiently and in depth, pulling out key areas of learning for the organisation where this had been identified.

The service was run by two enthusiastic and visionary registered managers whose skills complimented one another. They had a shared vision for the service and promoted the wellbeing of people using it at all times. Quality assurance was detailed and uncompromising revealing whether further work needed to take place which was then completed.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff demonstrated a sound understanding of what may constitute a safeguarding concern and knew how to report this.

The service had detailed records with appropriate actions which were reflected in the risk assessments for each person.

Staffing was appropriate to the needs of the people in the service and medicines were stored and administered safely.

Is the service effective?

Good

The service was effective.

Staff received regular and personalised supervision and training to ensure they were competent.

People's consent was sought for every undertaking and staff respected people's wishes when they did not wish to engage.

People had access to regular and nutritious meals within the service but also accessed the community during the day. They were also supported with all health and social care appointments and encouraged to engage with these services.

Is the service caring?

Good

The service was caring.

Staff were caring and considerate, respecting people's privacy but encouraging them to interact where appropriate.

People were actively involved in planning their daily support needs and the service was based on meeting their needs in the way they chose.

Staff demonstrated positive examples of respecting confidentiality and promoting respect.

Is the service responsive?

Good

The service was responsive.

People were actively involved in completion of their support plans and agreed their goals in conjunction with their keyworker. There were regular reviews with external professionals.

Complaints were handled appropriately and in a timely manner.

Is the service well-led?

Good

The service was well led.

The service had a positive atmosphere and promoted people's recovery which was evidenced through some people moving on to more independent living.

Staff were supported with two registered managers who both had vision and commitment to the service, taking it through a period of significant change while ensuring the support of individuals in it remained at the heart.

The service had a robust and effective audit system in place which identified areas that needed improvement and actioned them.

Trinity Street

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 1 February 2016 and was unannounced. The inspection team consisted of one adult social care inspector and a specialist advisor with experience of working with people with mental health needs and autism.

We asked the provider to complete a Provider Information Return (PIR) which was sent to us. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also checked information held by the local authority safeguarding and commissioning teams.

We spoke with two people living in the home and one of their relatives. We spoke with five staff including two support workers, the team leader, and both registered managers. We spent time observing people in the service but were aware our presence added to their unease so we did these discreetly.

We looked at all four care records, three staff personnel records, minutes of staff and resident meetings, complaints and audits including safeguarding, accidents, medicine administration records and the registered provider's quality assurance assessment.

Good

Is the service safe?

Our findings

We asked staff about their understanding of safeguarding. One member of staff was able to explain the signs of abuse and told us they would "report any concerns to the team leader, then the manager and if they did nothing I would ring the local safeguarding team then CQC."

It was evident from the very comprehensive records that were kept that the service understood their responsibilities. Records were kept of each incident which showed what had happened and what action had been taken to immediately safeguard the individual if this was needed and the subsequent investigation. Due to the fluctuating mental capacity of some individuals in the service, it was clear that staff had endeavoured to support them as much as possible by offering solutions such as when one person had alleged money had been stolen. This was proven not to have been the case but the service offered the person a safe or locked box to ensure their valuables could be secure. However, this was refused by the person despite repeated attempts by staff to explain the risks and offer solutions.

We saw that each incident was logged on the electronic recording system by the staff member who had been alerted. This was then scrutinised by the registered manager who provided further instruction, if needed, as to any further action that needed to happen. This was then cascaded to the regional manager who approved the action taken, and again if required, offered further advice as needed. This level of scrutiny was particularly important as the service was supporting people with complex mental health needs who would not always make decisions in their own best interests and needed staff to guide and consider all options.

There was recording of one incident where someone refused to accept medical attention despite being in a state of collapse but the service had put in various plans to support the person to manage both their physical and mental health needs should this happen again. There had been extensive discussion about this person's capacity to make informed decisions which was completed in conjunction with local healthcare services including the GP. This incident showed the service's ability to go extra lengths to support someone who should have been in hospital due to their condition and cared for this person in an exceptional manner to ensure they recovered as far as they were able. This incident was overseen by the assistant director who offered further resources if required and recognised the staff's input over and above their expected role.

We found that each person had their own personal emergency evacuation plan in the event of a fire. They showed that consideration had been given to every possibility around managing someone with complex mental health needs including their non-cooperation in leaving the building in the event of a fire. Plans reflected an individual's specific needs and offered a variety of methods to support someone. The fire alarm was tested on the day of inspection.

Each care record we saw had a Herbert Protocol in place which is an national initiative supported by West Yorkshire Police which encourages carers and care homes to compile useful information which could be used in the event of a vulnerable person going missing such as a photo and key physical description information. This had been signed by the person themselves so they were aware this information would be

shared in the event of them going missing.

We asked staff how they supported someone whose behaviour may, at times, become more challenging. They said "We have staff meetings and this is brought up and we talk about it." We asked if this information was recorded in the person's file and one staff member referred us to the risk assessments.

Risk assessments were detailed outlining the actual risk, the likelihood of occurrence and the impact of this. This resulted in an overall risk rating. The assessment then outlined the risk controls in place and how these then affected the overall risk rating. For example one person was at risk of non-compliance with medication when under the influence of alcohol so measures were put in place to minimise the likelihood of this non-compliance such as staff ensuring they offered the person their medication and kept in close contact with other health professionals during such periods to ensure monitoring and swift decision-making if further input was needed. This was also reflected in another example where measures had been put in place to observe someone at regular intervals if they became inebriated and there was a clear action plan for staff to follow if the person left the building. This included safeguarding measures in place for the staff as the person could sometimes become violent.

The staffing team comprised people who had worked at the service for some years and who evidently knew the people in the service really well. This, however, was not always helpful as we found staff were sometimes complacent in their approach basing their decisions on 'we know them all.' On the day of inspection there were enough staff to support people in the service.

We saw in staff records that appropriate recruitment procedures had been followed including the obtaining of references, identity checks and Disclosure and Barring checks. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with vulnerable groups. Staff had been subject to a rigorous interview process and the records of their interviews were in their files. This shows the service was targeting their recruitment to ensure the correct balance of skills and personal characteristics.

Medicines were stored in individual locked cupboards on the wall apart from one person who self-administered their medication. We saw that two staff always supported medication and staff washed their hands prior to administration. The individual who self-medicated brought all their medicine into the treatment room which they placed on a table in front of staff. This person's Medication Administration Record (MAR) sheet was checked and staff supported the person in putting specific medicines into a pot. They showed this to staff and they took their medicine with a drink. The MAR sheet was signed by staff on the back to show they had witnessed the person taking their medication. No one in the service was on covert medication or controlled drugs as defined in the Misuse of Drugs Act 1971.

Stock levels were checked twice daily to ensure amounts correspond with the records. We found no concerns with this. We noted that expired medication was kept in a separate box and a log sheet was completed indicating that it had been returned to the pharmacist. We did highlight to the registered manager that it was important to have the date recorded as to when it was returned so that appropriate checks could be made. They remedied this with immediate effect.

The service conducted weekly audits in addition to the daily stock checks where they looked at if any PRN (as required) medication had been given to anyone and the reasons why recorded, whether records were complete and correct and whether stock levels tallied. No issues had been identified within the past three months. We saw that all staff had received annual updates in administering medication and the team leader would address any issues via further training and observation of their competency.

The last infection control audit had seen the service score 91% in November 2015 which showed that infection control measures were working effectively and that staff adhered to the guidelines strictly. The service had handwashing posters on display throughout each building.

Good

Is the service effective?

Our findings

One person told us "The food is good and there is plenty." Another said "I like the food portions and it's tasty." One staff member advised us that food was in each bungalow's kitchen and people could access this at any time under supervision. This was to ensure that people had a balanced a diet as possible. We saw a range of breakfast cereals out on the side for people to help themselves and they were supported to make their own lunch. Staff tended to cook the evening meal and as there were only four people in the service they preferred to eat together in the central bungalow. People chose the week's menu at the weekly meeting held on a Tuesday and were offered alternatives if they did not like the main option.

We looked at staff files and found records of a detailed induction. This lasted for a period of twelve weeks and incorporated topics such as health and safety, communication, training needs, quality assurance, working with service users around their recovery and needs analysis. During the learning about these specific areas staff were signposted to key policies and procedures with which they were to familiarise themselves. We saw in two files this had been completed in the relevant timescale, signed and completed by both employee and the registered manager.

Staff had regular supervision with most staff having received six sessions over the past year including one group supervision session. Individual supervision sessions included discussions around the staff member's wellbeing, their involvement in the team, workload and training development. At each juncture staff were involved in the discussion and it was clear that the process was two-way. Each discussion had the subject area, agreed decision/outcome, how and when this was achieved, what support was required to enable a staff member to fulfil these, and an agreed timescale for completion. Records were signed by both employee and registered manager.

Discussions had occurred about how to manage staff's stress levels as the service had had a period of lower staffing during the past year. This was partly due to the change of direction for the service. In one staff member's notes we saw it recorded "I feel positive about the way the service is headed as this will give me more challenges and also opportunity to use skills I've used in the past such as working within time limits to move people forward." We also saw that this staff member had the lead for one area of the service which demonstrated that the service was keen to develop staff skills and use their experience.

We also noted that staff had received annual appraisals where their performance was assessed against agreed objectives which included quality support planning and person-centred care. These had been completed in conjunction with the staff's line manager and shared with the regional manager. They acknowledged where staff had performed well in regards to their specific roles and also where they had gone over and above their expected responsibilities and praised them accordingly. In one file we saw it recorded "[Name] is a skilled member of the team and has shared good ideas for service improvement. They are keen to progress service users and offer excellent support." This showed the service was recognising good performance and focused on service delivery as a means of assessing staff performance.

Staff were monitored to ensure they had completed all required training. In one file we saw it recorded that

the staff member had completed all their induction training, and an additional course on supporting people with suicidal tendencies and were booked on a mental health awareness course for the following month. The training materials were comprehensive. We saw a health and safety booklet completed by the staff member which incorporated areas such as accident and incident reporting, fire safety, manual handling, infection control and medicines. The information was obtained by a question and answer format and showed the staff member had to consider a range of issues.

We found staff were up to date with all the core training requirements including medicines, fire safety, information governance, specific mental health conditions such as bipolar disorder, safeguarding and mental capacity.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The service did not have anyone subject to a DoLS on the day we inspected although it had previously had restrictions on one individual due to safeguarding concerns. However, this had now been resolved and was no longer in place. We discussed what happened to one person when they were intoxicated as they lacked capacity to make decisions at these points but the service evidenced support plans in this person's best interests, showing compliance to the principles of the MCA.

People were encouraged to accept health and social care appointments as often as possible., However, given some people's reluctance to engage this was something the service endeavoured to promote. We saw one person had type 2 diabetes which was well controlled but we could not find a related risk assessment for staff on what action to take if the person had a hyperglycaemic attack due to high blood sugar levels. However, we did see that the service had supported the person to attend the diabetes clinic where they had had blood tests and eye screening. As the person's blood sugars had reduced the service did not feel there was a high risk of such an attack.

We could see that people attended appointments with their GP when they had infections, and had regular medication reviews completed by the hospital. People had also seen the dentist and optician although not always waited until the end of the appointment. One person had support from the district nursing service and another from the podiatrist. It was clear in people's support plans that help was obtained from other agencies as soon as it was needed but that people did not always choose to engage with this. Staff respected these decisions and continued to advise people of the value of receiving the support on offer.

The environment was clean and well furnished with accessible kitchens and communal areas provided with a TV, DVD player and books along with sofas. People could also use the computer. The service provided all bedding and furnishings and people were encouraged to decorate their rooms to suit their own preferences. We saw that one person had recently redecorated their room in their own choice of paint and another had chosen the colour in one of the communal lounges.

We were advised people tended to group together during the evening as most preferred to go out during the

day. People had their own keys to their bedrooms and the bungalow. There was an enclosed back garden with seating area and the building was non-smoking. However, we did notice a strong odour in one person's bungalow and staff were consistently reminding the person of the new rules which disallowed smoking. Staff provided regular monitoring visits to this person to minimise the likelihood of this happening.

Good

Is the service caring?

Our findings

One person told us "They look after us well." Another person said "Yeah, I like the staff. They do a good job at what they do." Observations were limited during the day as three of the people went out and the fourth person did not want to meet with us. However, when we did see staff interactions it was very clear that people responded well and were reassured by staff who explained who we were.

On our tour of the premises staff were very careful about what they said and where they said it, mindful the whole time of the importance of respecting people's confidentiality. They were careful to ensure doors were closed and always spoke to the person first, seeking their permission to talk to them before proceeding with any other questions. This showed that staff were fully aware of the importance of accepting people's mental health needs and minimising distress by having strange people in the service.

We saw that people were fully involved in writing and reviewing their support plans. In each person's file we saw evidence of three monthly reviews with their keyworker to discuss progress for each of the support plans, and if the person needed any more help with any particular aspect. It was evident from what was recorded how much they had been determined by the individual. All the support plans were signed and dated by the person and their keyworker, and a copy was kept in their room for their own reference.

Each staff member we spoke with had an in-depth understanding of people's needs evidenced by the knowledge they had about each person's personality and their specific likes and dislikes. We asked staff how people got on with each other given the lack of numbers but they stressed there was a positive atmosphere and people enjoyed eating their meals together during the evening.

Good

Is the service responsive?

Our findings

People's support plans were person-centred, focusing on key goals. They included areas such as the person's mental health needs, their interests, preferences and choices, living skills, healthcare needs and home design. One person's support plan focused on their objectives to manage household chores as they would soon be moving onto more independent living as the service altered. It was evident from the information within them that they had been written in conjunction with the person as they reflected their preferences and choices. Any initial assessment also contained key diversity characteristics to help inform staff in relation to their input and conduct.

The support plans enabled staff to access the person's world from that individual's perspective and consider how they would achieve specific things. They showed how the person would undertake specific activities and what support the staff needed to offer to enable this to happen. We saw in one person's file where they had achieved a specific objective and a meeting had been held with them to discuss what they would like to consider next. Each individual had a weekly keyworker session where their support plans and activities for that week were discussed and planned in a private and quiet environment. The keyworker was responsible for ensuring the effective implementation and review of the support plan.

Each support plan had been evaluated on a regular basis, ensuring that where a person had achieved their objective this was recorded and areas that needed further development were explored in more depth. In addition to the specific support plans, each person had a skills progress sheet. These gave details of what the person had done, the skills they had learned, how they had achieved these skills and how the person demonstrated their understanding of the completion of these. People held their own copies which they kept in their rooms.

In the daily planner which was stored with the staff handover information, each person had specific tasks to complete such as changing their bedding or doing their washing. There was evidence that where a person had chosen to do something else instead, this had been recorded showing what they had done as an alternative.

The service was able to produce care summaries for external health and social care professionals based on people's support plans which were used for ward rounds, care programme approach (CPA) meetings and care reviews. We saw details of regular reviews with external professionals and the actions form these meetings had then been translated into support plans with agreed objectives and a method of evaluating the success.

We looked at the Comments, Complaints and Compliments file and saw the service had received a letter from a clinical psychologist, praising the staff for great work with one person around their recent diagnosis of autism.

One person in the service had made many complaints about staff asking them too many questions about private things and on another occasion staff not allowing them to decorate their room. The locality manager

who was also one of the registered managers, had responded to each letter by a private letter to the person which answered their concerns respectfully and offered reassurance. Investigations had occurred into each complaint and the findings shared. Each complaint was tracked clearly with a receipt date, investigation findings, actions taken (where necessary) and replies. We saw in all cases that responses were appropriate and considered, all promoting the wellbeing of the people in the service.

Good

Is the service well-led?

Our findings

One relative we spoke with said "Staff do the job." We spoke with one staff member who told us "I enjoy working here as it's a good house."

We saw that the model of care was more reflective of a supported living environment with a view to independent living as people left the home as often as they liked and had support for key tasks although staff were available 24 hours a day. The main ethos was around recovery with each person having specific goals to achieve supported by detailed risk assessments. People were supported to develop a sense of self worth through the building of their self esteem and mutual respect for each other. The registered manager told us the service's vision was to be more focused on co-production with an equal partnership between staff and people using the service.

The service is in a state of transition as the registered provider is moving towards providing a six bedded complex mental health support unit with two independent flats and a four bedded personality disorder unit. The staff were working with people to support them with the forthcoming changes as some would be moving into different accommodation.

We observed positive interaction between the people living in the home, especially two who shared one of the bungalows. They were watching TV together in one of the communal lounges and told us they enjoyed living together.

We saw evidence of weekly meetings for people in the service. The menus for the week were decided at these meetings and people chose their evening meals which were cooked for them by the staff. We saw that one person had specified 'chilli con carne with pasta, sausages, mash and cabbage and bubble and squeak." These were incorporated into the menu the following week. The meetings also provided the opportunity for people to discuss how they felt the service was being run, offer alternative options and see them implemented. For example, we saw one person requesting support with doing a pop quiz for Christmas and staff had offered to support getting it into a written format. On another occasion people using the service were encouraged to take part in shopping for the food for the week and we saw one person saying they would like to join in this activity.

Staff meetings were held monthly and included discussion around each person's progress. This was also the opportunity for staff to raise any concerns. We saw that staff were involved in discussing the updating of support plans and risk assessments and progress was checked at the following meeting. There was also information about forthcoming training and audits within the home.

Staff had also received a team practice supervision session where the progress and planned support of people using the service was assessed overall. In addition, it was an opportunity to discuss possible new approaches, assessment tools and mentoring roles within the team structure.

We asked staff if they felt supported in their role. One staff member replied "The manager is good for the

staff as they were straight to the point." We saw in staff files that one staff member had felt comfortable in raising concerns about another member's staff conduct and this had led to disciplinary action. This showed the service had the confidence of its staff to discuss issues and take action where required.

We asked the registered manager what they felt the key risks to the service were and we were told "the real risk of closure at the moment as the service is so small. It's a critical time as we evolve into a new venture." They also said "It's important that staff don't take their eye off the ball even though we only have four people at the moment. We are keen to develop staff skills and training to ensure they are ready to meet the needs of the new people coming into the service." They also spoke with us about key risks to the individuals using the service, again displaying an in depth understanding of people's progress and current difficulties.

In one of the records about a safeguarding concern we saw that the registered manager was keen to ensure regular reflection. It was noted "Are we making sure we are doing everything we possibly can?" This was evidence that the service continually reviewed its impact and support offered to the people using it, and was open to all staff to contribute to this discussion and consider other options. We saw that staff had contributed to the discussion of this person's support needs through the input which followed for that individual. The registered manager was keen to stress that with any incident, there was specific scrutiny and then more general learning points discussed at handovers and supervision.

We spoke with the registered manager about the service's key achievements and one example was that someone had not required hospital treatment for their mental health issues for over seven years and another person had moved onto independent living. They felt these were positive indicators that the service was delivering high quality care and this had been reflected from feedback from external health colleagues. One person's GP had complimented the service on their 'fantastic care' saying the person would not get better anywhere else.

The registered manager advised us that they ensure good practice by not imposing models from elsewhere but looking at the specific needs of this service and unpicking the areas for development. "I focus on the positive and develop this, especially in relation to staff development. If someone has a skill in particular area I would develop this." They displayed a real vision and passion for the service and although not always on site, evidently knew the people and staff well. They told us they were keen to recognise good practice of staff and demonstrated this through the promotion of one staff member to the position of team leader. They also said that staff in the service 'genuinely care' which helped promote a shared vision and ethos.

We saw evidence of monthly detailed audits of the service conducted by the registered manager. This picked up on issues from reports ensuring actions had been taken where required. Where an issue had been recorded, the registered manager investigated themselves and spoke with both staff and service users where appropriate to check understanding and implementation was satisfactory. The registered manager fed back to staff observed areas of good practice, for example the daily recording of fridge temperatures and weekly health and safety checks. We saw that the records of regular checks on the building including health and safety, gas safety and portable appliance testing (PAT). Audits were completed for medication on a weekly basis, infection control every month and there were in depth monthly manager audits.

The registered manager also noted 'a good atmosphere' and 'good interaction between staff and people using the service.' They also recorded their praise for staff who had "worked hard to lift their knowledge and have all shown significant improvement. Staff are working hard to motivate people in recovery and networking successfully with community resources." This shows the registered manager valued the commitment of staff and was aware of the importance of maintaining their morale during a period of change.

The service conducted an annual service user survey although staff were struggling to get people to contribute. However, the service had a service user suggestion box in the reception area along with many information leaflets about how to manage physical and mental health and held weekly meetings to facilitate as much feedback as people using the service would tolerate.

The service had also been subject to a quality review in October 2015 completed by senior managers. This looked at the physical environment, medication, day to day delivery and staff practice. The assessment was in depth and scrutinised all elements of the service. Each area was assessed by what the senior managers found and then action points were identified for the service to take forward. It was clear from the day we inspected that much of this had been achieved.