Langley House Trust

Chatterton Hey

Inspection report

Chatterton Hey, Exchange Street
Edenfield, Ramsbottom
Bury
Lancashire
BL0 0QH

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05 July 2016

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30 November 2016

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

This announced inspection took place on 5 July 2016. The service was last inspected in 2013 and the service was found to be compliant with the requirements of the legislation at the time.

Chatterton Hey was a service providing support to men at risk of offending. The service was registered with the Care Quality Commission for accommodation for persons who require treatment for substance misuse and accommodation for persons who require nursing or personal care. At the time of inspection, the service was not providing the regulated activity, accommodation for persons who require treatment for substance misuse. The parent company, Langley House Trust, was a Christian organisation dedicated to improving the life chances of ex-offenders and helping them lead crime free lives.

There was a registered manager in place who oversaw the day to day running of the service. 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.

Chatterton Hey was a 15 bed house for males only with 24 hour support on site. The service was located in Edenfield, Lancashire and accepted referrals nationwide. The majority of referrals came from the criminal justice system including the probation service. Others came from forensic mental health inpatient services.

We found that there were enough staff, and that staff were regularly supervised and appraised. Additional training was available to staff. Staff knew when and how to make a safeguarding referral. Staff had a good knowledge of the Mental Capacity Act, and there was a Mental Capacity Act policy for them to refer to if needed. Consent to treatment was recorded in people's care records. Food was healthy and of good quality, and there was a range of activities available seven days a week.

People described staff as caring and respectful, and we observed positive interactions between people and staff. Care plans contained detailed information specific to each individual. People were consulted about changes to the service, and were involved in recruitment of new staff, The service has strong links with police and probation services. People felt confident about making complaints. Managers and senior managers had a visible presence in the service, and staff morale was good.

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

There were enough staff, medicines were managed well and the building was clean.

Is the service effective?

Good

Staff received regular supervision and appraisal, and had access to role specific training. People were supported to eat healthily and to access physical and mental health treatment as appropriate.

Is the service caring?

Good

People described staff as caring and respectful, and we observed positive interactions during our visit. People were involved in their care and in decisions about the service.

Is the service responsive?

Good

Care plans had been adapted to meet people's needs, with reasonable adjustments being made for those with a learning disability.

Is the service well-led?

Good

Managers and senior managers were a visible presence within the service and there was high morale among staff members.

Chatterton Hey

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 5 July and was announced. The provider was given 20 weeks' notice in line with mental health hospitals approach to inspections. This was because the service was incorrectly registered as providing the regulated activity "accommodation for people requiring treatment for substance misuse".

The inspection team was carried out by a team of two inspectors.

Before the inspection, the provider completed a Provider Information Return (PIR). 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 gathered feedback from five community care coordinators and commissioners, and reviewed the notifications and enquiries CQC had received on this service over the previous twelve months.

During the inspection visit the inspection team visited the location, looked at the quality of the physical environment, and observed how staff were caring for people using the service. We spoke with five people using the service, three carers, the registered manager, two senior managers and eight other members of staff. We reviewed minutes of daily handover meetings and client community meetings, three care records, six incident reports, medicines management procedures and other policies and documents relating to the running of the service.

Good

Is the service safe?

Our findings

People and carers we spoke to reported that the service was always clean and tidy, and that the furniture was in good order.

The service was providing placements for people who presented with risky or challenging behaviour. We reviewed incident reports, which showed that one of the people living in the home had been involved in 28 incidents between 20 January 2016 and 20 June 2016. These included five assaults of staff, one assault of another resident and 11 incidents of aggressive behaviour. Staff told us that if this person had hold of them, they would push against the person's chest with the palm of their hand, using the least amount of force possible, in order to move to a safe place. This technique was also written into the person's risk management plan. Staff were not aware that there were more proportionate breakaway techniques that could be used in these sorts of situations. However, the technique was removed from the risk management plan when we raised concerns about it.
Risk assessments were up-to-date and comprehensive, and there was evidence that risks were being managed appropriately. For example, two people had been compelled to leave the property under the conditions of their probation.

We felt confident that staff were able to recognise and act on signs of potential abuse. Staff told us that they would alert their manager or on-call manager if they had any safeguarding concerns. All except one member of staff had completed safeguarding training as part of their induction or care certificate. The manager agreed to arrange training for this member of staff following the inspection. The provider had a comprehensive safeguarding policy, which was discussed yearly in team meetings. There was also information about safeguarding, including a list of telephone numbers, available in the staff office.

There had been no issues of staff bullying or harassment within the service. Staff described understanding the whistleblowing process and knew what to report. All staff felt able to raise concerns directly with the manager or the senior management team without fear of victimisation. Staff described feeling confident regarding their managers and that they were approachable and fair.

The provider is a Christian charity. The weekly activities schedule included Bible study and prayer meetings, and there were Christian-based posters and literature on the walls. Eighty-four per cent of staff had completed equality and diversity training. The service accepted referrals for people of all ethnicities and religions. It had some facilities for people with physical disabilities, for example ground floor bedrooms for people with mobility difficulties. A Muslim person described the support he had received during Ramadan as 'excellent', but an atheist person told us that the religious theme was overbearing and that his beliefs had been ignored. Atheism is a protected characteristic and we would encourage the service to consider the needs of those without a faith, to avoid any possible discriminatory practice.

People were usually placed in Chatterton Hey by their local authority, but they signed a tenancy agreement on arrival. People whose freedom was restricted had the appropriate authorisations in place (including probation, conditional discharge under the Mental Health Act 1983 and for one person, Deprivation of

Liberty Safeguards). Tenancy agreements included conditions related to the service's registration as a substance misuse service. All people had therefore consented to random and scheduled drug and alcohol tests and bedroom searches, regardless of whether they had a history of substance misuse. We saw from one person's risk management plan that he had undergone drugs tests and room searches, and we saw from the 'house rules' that people bringing alcohol on to the premises could be evicted. Staff considered people's capacity when people were signing tenancy agreements, so we had no grounds to doubt the validity of the consent. However we did consider these restrictions to be excessive for people's needs and would encourage the service to review their 'house rules' now that they have applied to remove the regulated activity of accommodation for people who require treatment for substance misuse.

Staff demonstrated good knowledge of identifying and recording of incidents. We examined six incidents on the electronic system and found them to contain comprehensive information, clear analysis and recommendations. The outcome of investigations and reviews were discussed with staff during group supervision sessions. When staff were involved in incidents themselves they were offered de-briefs immediately afterwards.

The provider did not allow visitors under the age of 18 years. This was made clear to clients, who were supported to meet with child friends or relatives in the community if they wished.

The service employed a manager, a deputy manager, two team leaders, 15 project workers, a cook, an administrator and two volunteers. There were no vacancies at the time of inspection. All 96 of the shifts that could not be filled by permanent staff (due to sickness or other absence) over the last three months had been covered by agency staff. The manager was able to request familiar staff members to ensure continuity of care for people. There were plans in place to increase the number of bank staff available to work in the service and so be able to reduce the number of agency staff. When new staff were recruited, people using the service were included on the interview panel.

Daily staffing levels had been estimated by matching shifts to meet the activities identified in people's care plans. There was a minimum of three staff on shift during the day and two at night (one awake and one asleep). On average there were seven staff on shift during the day, including managers. Extra relief staff could be used to meet the needs of people considered to have complex needs. All of the people we spoke to said there was enough staff to ensure that regular one to one sessions with key workers were never cancelled. Four out of five people said that no activities were ever cancelled. One person spoke about staff not being available to escort him to a community activity. However, we saw from our review of records that this was not a regular occurrence and staff endeavoured to facilitate all activities and scheduled appointments where possible.

The service also employed a consultant psychiatrist and clinical psychologist on a consultancy basis. The psychiatrist was available to people whose care plan and commissioner arrangements meant they required an in-house psychiatrist as part of their treatment plan. The psychologist visited the service on a weekly basis and delivered one to one therapies to people who required this. The psychologist also provided input into the team referral and assessment process.

Medical cover was provided by the local GP surgery. All people were registered and the GP was familiar with the service. Outside of daytime hours, people could access emergency NHS services. There was a system in place for managers to be available on-call for out of hours assistance.

We saw that poor staff performance was addressed promptly and effectively. For example, when project workers failed to pass their six month probationary periods they were initially offered support and the

probation period extended to nine months. When the staff did not improve enough to meet the standards of the role they were dismissed.

Medicines management within the service was good. There were effective systems in place regarding the ordering and delivery of medication from the local pharmacy. Medication was signed for on receipt into the building and was audited each night. Staff used a medicine administration record chart to record each person's medication, dosage, time and date. Staff recorded if the medication was taken or refused and noted any allergies or health complications. The documentation included a picture of the medication, a picture of the person and date of birth and address. Medication was stored in a locked medication room that contained a locked medication cupboard and a medication fridge. There were checks in place to ensure the fridge, room and cupboard were the correct temperatures for the safe storage of medication. People attended the medication room individually to ensure confidentiality.

All areas were visibly clean and well maintained. Rooms were furnished to a good standard. People were responsible for keeping their bedrooms clean and received support from staff on a weekly basis if necessary. A cleaner was employed to ensure the communal areas were cleaned on a regular basis. We examined the cleaning records and found comprehensive and thorough environmental checks. Handwash gel was also available for people and for staff to aid in the prevention of cross infection.

Good

Is the service effective?

Our findings

People told us that the support they had to attend community activities and one-to-one activities was excellent. People said that staff did their best to support them to achieve their goals and aims.

Staff employed by the service demonstrated a broad knowledge of people's histories and understood strategies to support their progress. All staff received regular monthly supervision by their immediate line manager. Line management was shared between the manager, deputy manager and team leaders. We examined the supervision records and found that supervision records were up to date, detailed and contained relevant information. All staff received monthly supervision and had an annual appraisal. Appraisals were up to date and included goals for the next 12 months. Staff had access to regular team meetings. Monthly business meetings were held to discuss operational issues within the service. Daily handover meetings occurred each morning between project worker staff to discuss any events in the last 24 hours. Peer supervision was also available for staff every two weeks. This was facilitated by the psychologist who chaired discussions around care planning and particular needs. This offered staff time for reflection and support.

Role-specific training was available for all staff. For example, six had completed additional fire training, six had completed training in writing incident reports, five had completed training in maintaining professional boundaries and three had completed training in personality disorders.

External training was also available which included three staff completing safeguarding in healthcare, twelve staff completing NVQ in health and social care and the manager was enrolled on an NVQ in management. Staff could also apply for study sponsorship to attend extra training that they had sourced independently. One staff member had recently completed training in cognitive behavioural therapy to enhance his role as referral coordinator. The administrator had recently completed extra training which included NVQ level four in administration, benefits training, volunteer coordinator training and attended the value for money champion workshop.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA.

Specific Mental Capacity Act training had been completed by 58% of staff. However, the Mental Capacity Act was also covered within the common induction standards training and care certificate training which 84% of staff had completed. Staff had a good awareness of the Mental Capacity Act and a policy was available for

staff to refer to if needed.

At the time of the inspection one person was subject to Deprivation of Liberty Safeguards and had his finances managed by the service under an appointee arrangement with the local authority. An application to renew the deprivation of liberty safeguarding authorisation had been submitted by the service. There was evidence of staff considering this person's wishes, feelings, culture and history when making decisions for him regarding his finances. Staff involved him as much as possible and used visual aids to help him understand and communicate.

Consent to treatment had been discussed with people and was documented in individual care records.

The service had a 'no touch' policy. This meant that staff did not use seclusion, segregation or restraint to manage people's behaviour.

We examined four care records, which were comprehensive, holistic and person centred. They included recovery goals and contained information regarding physical and mental health needs. There was evidence of participation and copies of keyworker one to one sessions and discharge plans. Other needs recorded included, hobbies and interests, sleep, drug and alcohol use, diet and nutrition, medication, finances, rules and expectations, relationships, education, employment and training and community involvement. However, one person with a learning disability and challenging behaviour did not have a positive behaviour support plan or equivalent. Staff used an outcome star rating scale to measure a person's progress through the service. This tool was developed by the service to specifically match the needs identified within the care plan. The recovery star (a nationally recognised tool for measuring outcomes) was also used with some people.

Personal information was stored in an electronic format that was secure and password protected. Any paper records were stored securely in locked cupboards in lockable offices. This ensured the confidentiality of people's private data.

Psychological therapy was available to all people who required it. This was delivered on a one to one basis and provided directly by the service. The psychologist was employed on a sessional basis and visited the service weekly. Types of therapy available was based on individual needs.

All people were registered with the local GP service. People were encouraged to attend the GP for physical healthcare treatment by staff as and when required. Staff were available to escort people to the GP surgery and healthcare appointments were prioritised by staff. Staff were available to encourage and support people to attend for specialist treatment at hospitals and clinics.

A health and fitness specialist visited the service on a weekly basis. Her role was to encourage healthier lifestyles and promote fitness and good diet. People were weighed regularly and anything of note was reported to the manager. One client was significantly underweight and was receiving extra supplements from the GP as a result of this intervention. The health and fitness specialist also encouraged group exercise which usually entailed a walk around the grounds. Other people went on regular bike rides with staff, one person attended swimming sessions and two people regularly walked dogs.

The service employed a cook to prepare and cook lunchtime and evening meals that were fresh and nutritious. People spoke highly of the food available to them. The cook ensured that people were given a choice of meals and adapted healthy and balanced meals to the weekly menu. Hot drinks and snacks were available to people throughout the day. The dining room contained a fridge and freezer that were

specifically for people to store food items. Fresh fruit and jugs of water were available to encourage people to make healthy choices. Posters in the dining room and other areas displayed information promoting healthy eating and exercise. Training was available to staff in nutrition and wellbeing; nine staff had completed this.

Rooms available to support treatment and care included; dining room, television lounge, medication room, a meeting room and three offices. Externally there were extensive gardens and grounds and a number of outbuildings including a large barn.

People had full access to their personal mobile phones and could make phone calls in their bedrooms. This promoted people's privacy and dignity.

Access to outside space was greatly encouraged by the service. People were supported to engage in gardening, DIY, and caring for chickens, rabbits and fish.

People could personalise their bedrooms. We saw evidence of bedrooms having pictures and photographs on display as well as other personal belongings. Bedrooms contained lockable storage cupboards so that people could keep valuable possessions safe and secure.

Access to activities was care planned on an individual basis. There were many activities arranged in house that were available seven days a week, these included woodwork sessions, fitness training, walking football, prayer group and Bible study, literacy and numeracy sessions, arts and crafts and psychology sessions.

People were encouraged to participate in community based activities as much as possible. Staff supported people to attend these activities if necessary. Each person identified their own interests and goals and the service endeavoured to meet them. Community activities people were involved in included, paid probation work, voluntary work, addictions counselling, music group, and anxiety management groups.

People had also achieved qualifications while living at Chatterton Hey. These included first aid, food hygiene, blacksmithing and permaculture.

Two people were involved in voluntary work and paid employment. The volunteer worked in retail at a local charity shop. The other person was paid to deliver training to the probation service and NHS staff. The role also involved speaking at conferences as an "expert by experience". This showed that services valued the person's thoughts and views.

Good

Is the service caring?

Our findings

People told us that staff were caring, respectful and doing their best to help people improve their lives. One person and carer said that the support offered during Ramadan had been above and beyond their expectations. All people reported feeling involved in their care plans and in decisions about the service. People explained how staff encouraged them to complete goals and were genuinely interested in their progress.

Staff interacted with people in a caring and professional manner. We observed staff demonstrating respect for people offering discreet practical and emotional support. Staff spoke about people using positive and enabling language. Staff showed good understanding of people's needs. This was reflected in individual assessments, care plans and in staff discussions. Staff spoke about people's life histories, their current goals and plans for the future.

On admission, people were orientated to the service by staff showing them around. People received increased support during the first week following admission or longer if necessary. There was the option of a "buddy" if needed. People were actively involved in the care planning process. Care plans were developed collaboratively and included people's views and opinions. People were offered copies of their care plans and this was documented in the care records. All people said they felt involved in their care as much as they wanted. Care plans included information regarding further independence and long term goals. People were not encouraged to be involved in risk assessments. Staff believed that people would not benefit from reading negative risk profiles and associated reports. This information was shared verbally with people as and when required.

An independent advocacy service was available locally. Information about this was displayed on noticeboards. Staff were aware of how to refer. Staff and people told us this service was rarely needed and no referrals had been made in the last six months.

All people confirmed that their families and carers were involved in their care as much as they wanted. Families and carers were regularly invited to meetings. Staff supported a person to meet with his family on a regular basis who lived a long distance away.

People could give feedback about the service at fortnightly client meetings. This information was fed back to the manager who made changes where possible. This included adding movie channels to the television and arranging trips to the zoo. A person had been appointed as representative and acted as liaison between staff and other people living at the service. People completed an annual satisfaction survey, which was shared with the senior management team. The service had also developed a smaller local survey which was completed every six months. We saw that feedback from both surveys was positive.

People were consulted regarding changes to the service. People had recently been involved in various improvements to the service, which included decorating the television room, creating a garden walk and adding a memorial plot to the garden. People were involved in choosing the designs and supported to

complete practical work such as painting and decorating.

Good

Is the service responsive?

Our findings

There was a clear referral and admission process. There was basic referral criteria which included the following, must be over 18 years old; must be at risk of offending; must not be employed or have a family member employed by the service; not be a child sex offender.

The service employed dedicated staff to fulfil the role of assessing referrals. Referrals were received into the central referrals team and assessed for their suitability. They were then allocated to a staff member to conduct an in-depth assessment. This was based on information contained in the probation risk assessment, previous convictions, psychological assessment and parole report.

A face to face assessment was also completed with the client. A decision to proceed with the referral was made based on this information. Staff liaised closely with the referring organisation to develop a discharge plan and agree a length of stay. There was a service level agreement with the Ministry of Justice which ensured there was oversight regarding the location of particular people. There were strong links with the police, probation, Ministry of Justice and the multiagency public protection arrangements groups. This supported people to transition without delay into the service. A member of the referrals team remained involved in the care planning and risk assessment stage to support the service to understand the client's needs and risks.

There were nine discharges from the service in the last 12 months. Three people were recalled back to prison due to breaches of their licence agreements and six people had been discharged successfully to community settings. All had received follow up support during the first week of discharge from the service.

Leaflets about the service were available in easy read format and large print for people who required this. A person questionnaire and a review of the service were available in video form. Braille and other languages were not available; however, this could be arranged if needed. Access to interpreters or signers was accessible via Langley House Trust.

Food was prepared to meet the individual needs of people such a special dietary requirements or religious beliefs. The cook was experienced in preparing food that was gluten free, vegetarian, vegan and halal. The cook had recently prepared meals for a person who was observing Ramadan. A meal was prepared and staff cooked this late in the evening for him. The person commented that the support he received for Ramadan was the best he had ever experienced and highly praised the staff for exceeding his expectations. The weekly menu also included a meat free day so people could experience vegetarian dishes.

Christian spiritual support was frequently available on site. A Chaplin visited weekly and there were weekly prayer meetings and bible groups. People were supported to attend places of worship. In 2015, the service encouraged staff and people to visit a mosque to reduce social barriers and discrimination. A Muslim person said he felt his religion was respected by staff and that he was supported as much as possible.

The service had received two complaints from people in the 12 months prior to inspection. One complaint

related to the noise of the chickens and the other was regarded a person's lost or stolen aftershave. Both complaints were upheld by the service and addressed appropriately. There were no complaints referred to the ombudsman.

People knew how to complain. A comments book was available for people to comment on any aspect of their care. There was a complaints box and people could also bring up issues during the fortnightly people meeting. Alternatively, people could address issues directly with staff either during one to one sessions or with the manager or other staff. People we spoke to said they felt confident to raise a complaint and that it would be dealt with fairly.

Staff explained they would direct any complaint to the manager, depending on the nature of the complaint. Staff knew how to escalate a complaint and would try to deal with the issue locally and informally if possible.

There were systems in place for feedback regarding complaints to be discussed with staff and for outcomes to be shared and acted upon. This was via team meetings and group and individual supervision.

Good

Is the service well-led?

Our findings

People said they knew who the managers and senior managers were within the service. One person said he had recently met with executives of the company.

The values of the service were 'responsibility, integrity, visionary and responsiveness'. These were underpinned by Christian values and beliefs that the service was based on. Prayers were read during daily staff handover meetings as part of the standard procedure. The service had a motto of "under-promise and over-deliver" and a mission statement: "as a Christian charity, our mission is to work with those who are at risk of offending, or who have offended, establishing positive foundations so that they can lead crime-free lives and become contributors to society".

Senior managers attended the service on a monthly basis. During the visit they engaged with people and other staff on an informal basis. Senior managers regularly ate meals with people and took part in conversations and activities. Staff and people clearly knew who the senior managers were in the service and described them as supportive and approachable. Staff also had the opportunity to attend conferences and meet staff and managers in other parts of the organisation.

Risk assessments were up-to-date and comprehensive, and there was some evidence that risks were being managed appropriately. For example, two people had been compelled to leave the property under the conditions of their probation. However, one risk management plan included advice to push a person away if they had hold of staff. Staff were not aware of other more proportionate breakaway techniques.

Supervision and appraisal rates were excellent. Appraisal rates were a key performance indicator and were discussed monthly with managers to ensure these targets were being met.

There were systems in place to ensure incidents were reported. There was a central team to analyse the incident data and feed back to the service. Staff knew how to report incidents and we saw evidence of comprehensive incident reporting. There was a process in place for feeding back information to staff regarding incidents, feedback and complaints. Information was shared during peer supervision, staff meetings and in emails. There was access to a weekly newsletter via email which included updated service information. Learning was discussed with staff and lessons learnt implemented.

Managers were aware of individual people's probation arrangements and reported any breaches immediately. However, there was a lack of awareness and understanding among staff regarding conditional discharge under the Mental Health Act. Managers were aware that people could be readmitted to hospital.

Key performance indicators were used to gauge the performance of the service. These included breaches of probation orders, offending behaviour, health and safety issues, person feedback, appraisal rates, audits, number of people in voluntary work, person meetings and the number of people gaining qualifications. This data was collated by the service and shared with the senior management team. The senior management team also visited the service on a monthly basis to provide support and conduct audits. Audit and

performance data could be used to inform plans to improve service delivery, where necessary.

The service manager had sufficient authority and administrative support to fulfil their role. The service employed an administrative assistant who dealt with financial aspects of the running of the service. The service manager was well supported by the senior management team and could make decisions independently.

The risk register was not specific to the service but was a nationwide document. The risk register included general risks that were common to all services within the organisation. The manager could add items to the risk register by raising any issues with the senior management team.

A person satisfaction survey completed in 2016 showed 88% of people were satisfied with the environment of their room. Ninety-five per cent were satisfied with the environment of the service.

The service conducted a staff satisfaction survey in February 2016 which was completed by 11 staff members. The survey showed positive results in the following areas, high quality training; good learning opportunities; feeling skilled; supported in professional development; good access to policies; knowing how to complain; valued opinions and beneficial supervision. Areas where improvement was required included, feeling supported in role; appraisal informs training; involved in appraisals and managers act on staff feedback. There was a plan to review these issues with staff during group supervision sessions and team meetings.

The staff sickness and absence rate for the last 12 months was 10%. This is above the England average of approximately 4%. However, this was due to two staff members being on long-term sick due to physical health issues which were not work related.

There was high staff morale throughout the service. Staff described excellent job satisfaction and felt empowered in their role. Staff had received team resilience training to help address any issues of stress. Staff demonstrated a supportive attitude towards each other and were able to provide each other with informal peer support. Staff were asked how they were feeling each day in handover meetings and this was recorded in the notes. Managers had oversight and were able to address any issues.

There were opportunities for leadership development for the service managers and team leaders. The service manager received monthly leadership coaching sessions from within the service and weekly leadership management sessions from an independent provider. The manager was also completing an NVQ in leadership. Three staff members had completed team leader training. However, staff who were not practising Christians could not progress into any leadership roles or training.

Staff demonstrated an open and transparent culture towards people. Staff provided examples of when mistakes were made and staff had apologised to the person and given an explanation. Staff endeavoured to rectify any mistakes as soon as possible.

Staff were regularly encouraged to give feedback on the service and new ideas were supported. Staff's views were listened to during clinical supervision, peer supervision and team meetings. Staff felt their views were listened to and considered fairly.

The service was focussed on improving links with the local community and strengthening relationships with the public. The service held regular open days. People participated in the event by providing refreshments to guests and other tasks. There had been a "bring a friend to work day" for staff. This had instigated interest in

people from the local community becoming volunteers.

The service had won internal awards in the last 12 months. These included effective financial management and person involvement, volunteer of the year and outstanding service and care.

The service had also achieved external recognition in the last 12 months by winning awards from Investors in People and Practical Quality Assurance for Small Organisations. The service was recognised by Laing Buisson for good risk management practices.