Leonard Cheshire Disability

Oaklands - Care Home with Nursing Physical Disabilities

Inspection report

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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

Overall summary

This inspection took place on the 22 April 2015 and was unannounced. We last inspected Oaklands on 6 August 2014 in response to safeguarding concerns raised in relation to how medicines were managed and staffing concerns. We found the service to be compliant regarding medicines management but found issues regarding how staff were deployed. These concerns were deemed to have a moderate impact on people who used the service.

As a result of our findings we asked the home to submit an action plan detailing how they would become compliant, and when, with regard to the breach in regulation. During this inspection we reviewed actions taken by the provider to gain compliance. We found that the necessary improvements had been made.

Oaklands is a Leonard Cheshire Foundation home providing care and support for physically disabled adults.

Summary of findings

The home is an adapted property situated on the outskirts of Garstang and is registered to accommodate a maximum of 27 persons needing nursing or personal care. The home offers a range of activities and support to meet the individual needs of people. The home has a number of lounge areas and a large dining area. The home provides short to long term care and a home for life.

There was a registered manager in place at the time 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.

The service had procedures in place for dealing with allegations of abuse. Staff were able to describe to us what constituted abuse and the action they would take to escalate concerns. Staff members spoken with said they would not hesitate to report any concerns they had about care practices. They told us they would ensure people who used the service were protected from potential harm or abuse.

We looked at how medicines were ordered, stored, administered and recorded. We spoke with three nurses who had responsibility for administering medication and observed medication being given to people over the lunchtime period. The nurse observed wore a 'do not disturb' tabard and spent time with people asking them if they needed any pain relief. This was done in a discreet manner. The nurse was able to explain what people took their medication for and what support they needed. All staff we seen to be very pleasant and supportive with the people they cared for and were knowledgeable about individuals.

We check medication administration records (MAR) for fourteen people to see what medicines had been given. The MAR were clearly presented to show the treatment people had received. A recent audit had highlighted that staff did not always record the dose clearly in cases of variable doses and further work was necessary to improve this.

The recording of topical creams was found to be inaccurate and inconsistent. A different form had been used for the cycle we looked at which had caused some confusion. We spoke with the registered manager who told us that they would take immediate action to ensure record keeping was improved and to include this area within future audits.

We saw there were detailed policies and procedures in place in relation to the MCA, which provided staff with clear, up to date guidance about current legislation and good practice guidelines. We spoke with staff to check their understanding of MCA. The majority of the staff we spoke with were able to demonstrate a good awareness of the code of practice and confirmed they had received training in these areas.

During our visit, we spent time in all areas of the home. This helped us to observe the daily routines and gain an insight into how people's care and support was managed. People were relaxed and comfortable with staff and it was evident that members of staff knew the people they were caring for well.

Staff were very knowledgeable when speaking about the individuals they cared for and it was evident during our observations that people knew the staff caring for them well. Staff showed warmth and compassion when speaking to people and were very attentive when dealing with any requests.

We saw that advocacy services were available for people to access if they did not have relatives or friends to act as a voice for them. One person was receiving support from an Independent Mental Capacity Advocate (IMCA).

People we spoke with and their relatives told us they knew how to raise issues or make complaints. We saw that the home had a complaints procedure and that it was made available to people, this was confirmed when speaking with people and their relatives. The majority of people spoken with told us they felt confident that any issues raised would be listened to and dealt with appropriately.

The home had a key-worker system in place which meant that each person had a named nurse and care-worker. When speaking with staff they were aware of who they were a keyworker for and were knowledgeable about the needs of those people.

There was a registered manager at the service at the time of our inspection who had worked at the service for

Summary of findings

approximately two years. There was also a newly appointed deputy manager at the home who had been employed to give the registered manager support. None of the people living at the home or their relatives spoke negatively about the manager, staff or culture within the home.

There were a number of systems in place to enable the provider and registered manager to monitor quality and safety across the service. These included regular audits and quality checks in all aspects of the service. This included medication audits, care plan audits and infection control.

Summary of findings

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.

People were protected from abuse and avoidable harm.

The home had processes in place to safely manage medicines. Regular audits took place to identify any issues quickly and continue improvements already made.

There were sufficient staff numbers to meet people's personal care needs.

Recruitment practices were safe and relevant checks had been completed before staff worked unsupervised.

Is the service effective?

Good

The service was effective.

During our visit, we spent time in all areas of the home. This helped us to observe the daily routines and gain an insight into how people's care and support was managed. People were relaxed and comfortable with staff and it was evident that members of staff knew the people they were caring for well.

The service had policies in place in relation to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). We spoke with staff to check their understanding of MCA and DoLS. Staff we spoke to demonstrated a good awareness of the code of practice and confirmed they had received training in these areas.

Is the service caring?

Good

The service was caring.

Staff treated people with patience, warmth and compassion and respected people's rights to privacy, dignity and independence. Observations we made and the people we spoke with confirmed this happened.

People were supported to express their views and wishes about how their care was delivered.

Is the service responsive?

Good

The service was responsive.

People we spoke with told us that the care they received was personalised and responsive to their needs.

The home had a complaints procedure and it was made available to people, this was confirmed when speaking with people and their relatives. People spoken with told us they felt confident that any issues raised would be listened to and dealt with appropriately.

We saw that care plans were regularly reviewed and contained information pertinent to each individual.

Summary of findings

Is the service well-led?

Good

The service was well-led.

There was a registered manager at the service at the time of our inspection.

There were a number of systems in place to enable the provider and registered manager to monitor quality and safety across the service. These included regular audits and quality checks in all aspects of the service. This included medication audits, health and safety, infection control, fire safety and staff training.

Oaklands - Care Home with Nursing Physical Disabilities

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 checked 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 the 22 April 2015 and was unannounced.

The inspection was carried out by the lead adult social care inspector for the service. A specialist advisor for medicines management and an expert by experience were also in attendance. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection visit we reviewed the information we held about the service, including the Provider Information Return (PIR) which the provider completed before the inspection. The PIR 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 looked at other information we held about the service, such as notifications informing us about significant events and safeguarding concerns.

We spoke with a range of people about the service; this included six people who used the service, two relatives of people using the service, twelve members of staff, including the registered manager, deputy manager, cook, nurses, care staff and activities coordinator. The expert by experience spent time talking to people and observing how staff interacted with people living at the home.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spent time looking at records, which included seven people's care records, four staff files, training records and records relating to the management of the home which included audits for the service.

Good

Is the service safe?

Our findings

People told us they felt safe at the home and with the staff who supported them. One person told us, "I have no issues with feeling safe, you can ask anyone here and they would tell you the same as me." Relatives we spoke with also told us that the safety of their loved ones was not seen as an issue. One relative told us, "The care (name) receives is outstanding. Staff are very approachable and responsive to any concerns."

The service had procedures in place for dealing with allegations of abuse. Staff were able to describe to us what constituted abuse and the action they would take to escalate concerns. Staff members spoken with said they would not hesitate to report any concerns they had about care practices. They told us they would ensure people who used the service were protected from potential harm or abuse. A safeguarding file was in place at the home that held copies of all safeguarding referrals made by the home. A full audit trail was in place for each alert raised including any actions taken to reduce the risk of reoccurrence. We saw good links with external organisations such as the local authority, hospice, tissue viability nurses and other health professionals in relation to safeguarding incidents.

We looked at how medicines were ordered, stored, administered and recorded. We spoke with three nurses who had responsibility for administering medication and observed medication being given to people over the lunchtime period. The nurse observed wore a 'do not disturb' tabard and spent time with people asking them if they needed any pain relief. This was done in a discreet manner. The nurse was able to explain what people took their medication for and what support they needed. All staff we seen to be very pleasant and supportive with the people they cared for and were knowledgeable about individuals. A number of people required their medicines to be administered via a percutaneous endoscopic gastrostomy (PEG) tube. We found clear records in place for these individuals. However a couple of people required their medicines before food and this had not been considered with the timing of the set-up of feeds.

The nurses we spoke with told me that they had received medication training within the previous twelve months and had their skills assessed by an external manager. We were told that two regular nurses carried out weekly medicine audits and night staff checked boxed medicines to assist the manager in identifying any errors which may occur so that action could be taken quickly. The registered manager told us that they had made significant progress with staff regarding medication procedures following a number of errors in the previous year and were in the process of recruiting regular nursing staff. The home was seen to be working with the local surgeries, pharmacy and care home pharmacist to improve communication and discuss the practical problems that had arisen during the previous year.

We found that medicines were being stored securely in separate medicine rooms on each floor. The nurses checked the storage temperature of the fridge and medication room daily to ensure they were within the required limits. We carried out checks on four controlled drugs medicines and found these to be correct.

We check medication administration records (MAR) for fourteen people to see what medicines had been given. The MAR were clearly presented to show the treatment people had received. A recent audit had highlighted that staff did not always record the dose clearly in cases of variable doses and further work was necessary to improve this. Handwritten MAR charts had been double checked and nurses made clear changes to the records when any medicines were stopped or the course had been completed. We found one error during the inspection. One person was prescribed a regular inhaler and this had not been administered to the individual for a few days, the nurse had recorded the medication as not needed. We spoke with the registered manager regarding this issue who told us they would investigate the matter immediately. The person affected had not suffered any ill effects as a result of the missed medication.

We found some excess stock of medicines. One of the nurses we spoke with told us that they had recently taken over the ordering of medicines to control the quantities ordered more carefully. They had been given protected time to do this. We found that some quantities of some medicines had not been correctly carried forward for the current cycle therefore it was difficult to reconcile some checks. However from looking at previous MAR charts we were able to see that this was usually completed and was not an issue.

We looked at five care plans specifically in relation to individual's needs for their medicines. Copies of hospital discharge information and GP letters were kept in the

Good

Is the service safe?

person's care plan, providing written confirmation of any medication changes. 'When required' medicines clearly described the treatment needs of the individual and protocols were in place for each person.

The recording of topical creams was found to be inaccurate and inconsistent. A different form had been used for the cycle we looked at which had caused some confusion. We spoke with the registered manager who told us that they would take immediate action to ensure record keeping was improved and to include this area within future audits.

Systems were in place for staff to assess risks for people and to respond to them. Records confirmed people were routinely assessed regarding risks associated with their care and health needs. These included risk of falls, skin damage, nutritional risks and moving and handling and community access. People's risks were reflected within individual care plans and ensured staff had guidelines to follow to keep people safe.

We found the home to be clean and tidy and infection control procedures were in place and followed by staff. The home had a top rating of 'five' for their food hygiene rating and had met the standards required during inspections from environmental health.

During our inspection we looked at the personnel records of four members of staff. We found that recruitment practices were satisfactory. Prospective employees had completed application forms, including health questionnaires and had produced acceptable identification documents, with a photograph. The disclosure and barring service (DBS) had been consulted before people were employed. The DBS checks criminal conviction records, so the provider can make an informed choice about employment in accordance with risk. Staff talked us through their recruitment and told us this was thorough.

We saw staffing levels were sufficient to provide a good level of care during our observations. This has been cited as an issue during our previous inspection, particularly in relation to permanent nursing staff. We spoke with five staff members about staffing levels at the home. All bar one agreed that staffing levels were in line with the needs of the people living at the home. The one member of staff who disagreed told us that they felt staffing levels at night were not sufficient. We discussed staffing levels and how staff were deployed in detail with the registered manager and went through the staffing rotas for the next two week period. People who lived at the home cited no issues with staffing levels. Relatives we spoke with on the day of the inspection also stated that they were happy with staffing levels and the attitude and competence of staff who worked at the home.

The home, due to its rural location, has experienced difficulties recruiting staff, particularly nursing staff. In response to this Oaklands has recruited two fully qualified Italian nurses who are undergoing their preceptor training to meet NHS requirements. They also receive numeracy/ literacy functional skills training at a local college. This was seen as a positive and effective initiative by Oaklands to get around their local recruitment difficulties experienced in recent years.

Good

Is the service effective?

Our findings

All of the people we spoke with told us they enjoyed the food provided by the home. They said they received varied, nutritious meals and always had plenty to eat. One person told us, "The quality of the food has improved greatly since we went back to sourcing food locally. The food is much fresher and the quality and choice of food has got better as a consequence. There is also going to be a third teatime option introduced."

We saw that drinks were regularly offered to people and their relatives and visitors during the inspection. Food and drink were brought to people carefully and placed on secure surfaces so that people could comfortably and safely reach their drinks and food as appropriate. Most of the people we observed had to be helped with their drink and food intake. Fluid vessels were used that best suited the needs of people e.g. straws, spoons, lipped cups etc. This maximised safety, autonomy and dignity for people. We saw where people who needed their fluid and food intake supervised and monitored this was done. One example was with a person that had type one diabetes. This person was at risk of choking when eating food so they had to be supervised when consuming food and drink.

Dining areas looked very clean, hygienic and safe. There were a sufficient number of staff in the dining room to ensure that the correct support for people was available. People had one-to-one attention and support. Six care assistants were available to support people in the dining room plus one nurse was present to provide lunchtime medication. Management also attended to provide additional support as required.

We saw evidence that the service worked with other professionals, e.g. NHS dieticians, to ensure that the provision of food and drink met the medical needs of people. Each person's dietary needs were carefully recorded and monitored so that kitchen and care staff knew the requirements of each person. This was reviewed on a regular basis in terms of weight, calorific intake, sugar levels, allergens etc. One person was having their meal choice monitored to assist them to gain weight via a calorie enriched diet. Vegetarian meals were on offer and halal or kosher provision could be organised with local suppliers, however there was no demand for either at the time of our inspection. In the kitchen and serving area there was an up-to-date chart that clearly defined the dietary requirements of each person. All kitchen staff and care assistants knew what dietary requirements each person had.

The Care Quality Commission is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS). We discussed the requirements of the MCA and the associated DoLS, with the registered manager. The MCA is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. DoLS are part of this legislation and ensures where someone may be deprived of their liberty, the least restrictive option is taken.

We saw there were detailed policies and procedures in place in relation to the MCA, which provided staff with clear, up to date guidance about current legislation and good practice guidelines. We spoke with staff to check their understanding of MCA. The majority of the staff we spoke with were able to demonstrate a good awareness of the code of practice and confirmed they had received training in these areas.

During our visit, we spent time in all areas of the home. This helped us to observe the daily routines and gain an insight into how people's care and support was managed. People were relaxed and comfortable with staff and it was evident that members of staff knew the people they were caring for well.

We observed throughout the day that people's consent was sought by staff at all times, either before entering people's rooms, when assisting people to mobilise or when assisting people with their medication.

Staff confirmed they had access to a structured training and development programme. This ensured people in their care were supported by a skilled and competent staff team. One staff member told us, "Training is good here, I have had safeguarding training, MCA, dementia, challenging behaviour and in a number of other areas." We saw good evidence of training within staff files.

From looking at staff files, talking with the registered manager and staff it was apparent that some staff had not had supervision as regularly as others. One member of staff we spoke with told us, "I haven't had supervision in the past twelve months. I have a date set for one in a few weeks' time though." We saw that other members of staff had not had supervisions or appraisals for a number of

Good

Is the service effective?

months however all staff we spoke with had either had a recent supervision or had one booked in. Staff did tell us that handovers and team meetings did take place and that these were useful.

Despite the age of the building we saw that the home was adapted appropriately for the people in the home. We also saw that work was ongoing in improving the environment for people. Several bedrooms had been updated and this was done in consultation with each person who resided within those rooms. Other improvements had been made to the home including a new gas central heating system. We saw specialist equipment in place such as track hoists in bedrooms, specialist profile baths, wet rooms and specialist beds.

The home had used a number of innovative solutions to communicate with those people who were unable to do so verbally. This included mouth operated and eye operated technology which had meant people who had not been able to communicate were now able to answer questions when asked with a 'yes' or 'no' response.

Good

Is the service caring?

Our findings

People we spoke with told us they were happy with the care they received at the home and that they had positive relationships with staff. One person told us, "I really like it here. It's a bit of all right. The staff are really friendly. I really like (staff member)." Another person said, "Staffing levels here are much better now. Staff need to be highly praised for the work that they do." Another person we spoke with who had complex care needs told us, "The nursing care is spot on. I feel very confident about the way I am treated in terms of my medical needs. I am turned in my bed every five hours. The team worked very hard to get me a bed big enough for me that I can control in terms of comfort. I know all my medicines are given to me properly and on time."

These views were backed up by the relatives we spoke with. One relative told us, "The care assistants are brilliant. All the staff are really caring. This is a very loving and supportive environment. At previous homes we have been very afraid to leave (name of relative). But here we feel very comfortable. The team put on a fantastic birthday party buffet with music and dancing for our son at Oaklands. Our relatives who came to the party said the staff are just amazing in the way they help people to enjoy themselves. We completely trust the staff here to do what is right by our son." Another relative said, "There is a lot of love on offer here. The atmosphere is very friendly and welcoming."

Staff were very knowledgeable when speaking about the individuals they cared for and it was evident during our observations that people knew the staff caring for them well. Staff showed warmth and compassion when speaking to people and were very attentive when dealing with any requests.

We looked at people's care plans. We saw within peoples care plans that referrals were made to other professionals appropriately in order to promote people's health and wellbeing. Examples included referrals to social workers, district nurses and peoples GP's. Care plans were kept securely, however staff could access them easily if required. We saw that people who were able to were involved in developing their care plans. This meant that people were encouraged to express their views about how care and support was delivered. People we spoke with confirmed they had been involved with the care planning process. Relatives we spoke with also confirmed this to be the case.

The home had policies in place in relation to privacy and dignity. Staff we spoke with were aware of the homes policies, signed to state they understood them and were aware how to access them. All the staff we spoke with, regardless of their role, understood the key principles of privacy and dignity. Our observations of staff interactions and discussions with people confirmed that this was the case. People told us they felt their privacy, dignity and independence were respected by the staff at the home. People were able to move independently around the home, if able to, and could access all areas of the home, including the large garden area outside, again if they were able to due to the limited accessibility of the large grounds.

Four members of care staff had attended end of life training entitled 'Six steps to success' via a local hospice. This is a widely recognised training course for end of life care. We spoke with some of the staff who had recently attended this training who told us that they had found it valuable. They told us that they felt they had the opportunity to discuss any training undertaken with management if they needed to. People were enabled to make end of life plans to ensure that care and support was provided in a person centred way and in line with their wishes. The home liaised closely with local palliative care and district nursing teams as well as local hospices when appropriate.

We saw that advocacy services were available for people to access if they did not have relatives or friends to act as a voice for them. One person was receiving support from an Independent Mental Capacity Advocate (IMCA). IMCA's provide independent representation and safeguard the most vulnerable members of the community.

Good

Is the service responsive?

Our findings

People we spoke with told us that the care they received was personalised and responsive to their needs. One person said, “Living in this home really suits me. I can come and go when and where it suits me. I can meet friends inside and outside of the home when it suits me.” Another person told us, “I feel very secure in this environment because if I need to go out Oaklands will provide a registered driver for me. I use my Motability allowance to pay for the fuel costs. But usually I go out under my own steam in a taxi.” There were several other examples given to us that evidenced that the service was responsive to people’s wishes and that people were given choices with regards to daily care and living routines.

We spoke to people and relatives about activities within the home. Activities are an important part of people’s care as they keep people active and can prevent social isolation. We spoke to the activities coordinator (AC) for the home who explained what types of activities were on offer for people who lived at the home and visited for day care. The AC explained that the holiday needs of all the people are accommodated as far as possible. All people are offered the opportunity to go abroad at least once a year to a destination of their choice. Accompanying staff are paid to support each person. People paid for their own holiday, but staff had their stay paid for by Leonard Cheshire.

The AC supported as many outings as possible throughout the year as well as many events within the extensive grounds of Oaklands. A variety of opportunities are laid on by the Oaklands staff including theatre visits to local towns and trips to the cinema and ten pin bowling. Trampoline and swimming sessions were also provided outside of Oaklands at local venues. A rota was organised to ensure that everyone had a fair chance to participate in these activities. There were nominal entry costs that were met by people. The management team were very keen to provide a wide variety of activities to meet the needs of people with any reasonable requests for activities and outings considered.In addition to activities and longer holidays weekend breaks had been organised for up to 18 people to attend. Examples included mini breaks to outdoor activities centres and other outdoor pursuits. We saw that such activities were fully risk assessed and the necessary consent forms were in place. Within the Day Centre people could take advantage of a range of creative activities such as: creative writing, gardening, massage classes, chair exercise classes, making ceramics with air dry clay, baking cup-cakes and making festive/anniversary cards etc.People we spoke with and their relatives told us they knew how to raise issues or make complaints. We saw that the home had a complaints procedure and that it was made available to people, this was confirmed when speaking with people and their relatives. The majority of people spoken with told us they felt confident that any issues raised would be listened to and dealt with appropriately.

We looked in detail at people’s care plans and other associated documents. We saw that people’s care plans were reviewed on a monthly basis and notes were written twice daily that documented how each person had been throughout that period. We looked at people’s care records to see if their needs were assessed and consistently met. Care records were written well and contained good detail. Outcomes for people were recorded and actions noted to assist people to achieve their goals.

The home had a key-worker system in place which meant that each person had a named nurse and care-worker. When speaking with staff they were aware of who they were a keyworker for and were knowledgeable about the needs of those people.

The home was aiming to introduce ‘resident, family and friends’ meetings in order to give people a further platform to given their views on the service. This was seen as an important addition as a number of people at the home were unable to verbally communicate so the input of family and friends was invaluable. The meetings would focus on specific topics such as complaints and activities.

Good

Is the service well-led?

Our findings

There was a registered manager at the service at the time of our inspection who had worked at the service for approximately two years. There was also a newly appointed deputy manager at the home who had been employed to give the registered manager support. None of the people living at the home or their relatives spoke negatively about the manager, staff or culture within the home.

All the staff we spoke with told us they had a commitment to providing a good quality service for people who lived at the home. Staff confirmed that they had handover meetings at the start and end of each shift, so they were aware of any issues during the previous shift. We found the service had clear lines of responsibility and accountability. Most of the staff members confirmed they were supported by their manager and their colleagues. One staff member we spoke with told us, "The staff here are brilliant, we all help each other." Another told us, "I certainly have no issues with the support I get, everyone is friendly and helpful and we are able to ask questions if we need to. Staff morale has definitely improved". However one member of staff told us, "I don't find management to be particularly approachable. I think some people feel if they raise issues it would affect their position." We discussed these comments with the registered manager as part of our feedback at the end of the inspection to make them aware of them.

There were a number of systems in place to enable the provider and registered manager to monitor quality and safety across the service. These included regular audits and quality checks in all aspects of the service. This included medication audits, care plan audits and infection control.

Service contracts were in place, which meant the building and equipment was maintained and a safe place for people living at the home, staff and visitors. We saw service files in place to evidence this, which were well organised and up-to-date.

The home and manager, as part of the Leonard Cheshire organisation, was supported by a number of national teams. These included; property teams, finance support, human resources, contracts and a quality team as well as advisors for safeguarding, nursing and health and primary care physician (PCP).

The organisation had a whistle blowing policy in place which meant staff who felt unable to raise issues with their immediate manager were able to confidentially raise issues via that method and remain protected. Support was also available via a staff association and employee assistance programme.

We saw that monthly management meetings were held between the head of department and team leaders to ensure communication was consistent within the home. We also saw that good links were in place with eternal organisations such as the local authority, NHS, GP surgeries etc. The home was also looking to improve links with the local community by holding community events within the grounds of the home, one example being a summer music festival.

The registered manager told us that they would look to improve support to staff by introducing a more robust supervision and appraisal development programme to ensure that all staff received regular one to one sessions with their line manager and an end of year review. We saw that this process had already begun to happen and staff we spoke with confirmed this.