An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 023

Year: 2021

Inspection Report

Year:	**2021**
Name of Organisation:	**Fresh Start**
Registered Capacity:	**Four young people**
Type of Inspection:	**Announced**
Date of inspection:	**07th and 08th April 2021**
Registration Status:	**Registered from 13th September 2019 to 13th September 2022**
Inspection Team:	**Linda Mc Guinness** **Joanne Cogley**
Date Report Issued:	**10th June 2021**

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1. Information about the inspection process

The Alternative Care Inspection and Monitoring Service is one of the regulatory services within Children's Service Regulation which is a sub directorate of the Quality Assurance Directorate within TUSLA, the Child and Family Agency.
The Child Care (Standards in Children's Residential Centres) Regulations, 1996 provide the regulatory framework against which registration decisions are primarily made. The National Standards for Children's Residential Centres, 2018 (HIQA) provide the framework against which inspections are carried out and provide the criteria against which centres' structures and care practices are examined.
During inspection, inspectors use the standards to inform their judgement on compliance with relevant regulations. Inspections will be carried out against specific themes and may be announced or unannounced. Three categories are used to describe how standards are complied with. These are as follows:

- **Met:** means that no action is required as the service/centre has fully met the standard and is in full compliance with the relevant regulation where applicable.
- **Met in some respect only:** means that some action is required by the service/centre to fully meet a standard.
- **Not met:** means that substantial action is required by the service/centre to fully meet a standard or to comply with the relevant regulation where applicable.

Inspectors will also make a determination on whether the centre is in compliance with the Child Care (Standards in Children's Residential Centres) Regulations, 1996. Determinations are as follows:

- **Regulation met:** the registered provider or person in charge has complied in full with the requirements of the relevant regulation and standard.
- **Regulation not met:** the registered provider or person in charge has not complied in full with the requirements of the relevant regulations and standards and substantial action is required in order to come into compliance.

National Standards Framework

1.1 Centre Description

This inspection report sets out the findings of an inspection carried out to determine the on-going regulatory compliance of this centre with the standards and regulations and the operation of the centre in line with its registration. The centre was granted its first registration on 13th September 2013. At the time of this inspection the centre was in its third registration and in year two of the cycle. The centre was registered without attached conditions from 13th September 2019 until 13th September 2022.

The centre was registered to provide medium to long term care for four young people of both genders from age thirteen to seventeen years on admission. On occasion, and in consultation with the alternative care registration and monitoring service the centre accepted referrals for young people under 13 years under a derogation to the statement of purpose. There were four young people living in the centre at the time of this inspection. One was placed in line with this derogation process and another young person was placed from another jurisdiction under Article 56 of EC Regulation 2201/2003. Their model of care was described as therapeutic care in a residential setting with a focus on needs based assessment.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
3: Safe Care and Support	3.1, 3.2, 3.3
6: Responsive Workforce	6.1, 6.2, 6.3, 6.4

Inspectors look closely at the experiences and progress of children. They considered the quality of work and the differences made to the lives of children. They reviewed documentation, observed how professional staff work with children and each other and discussed the effectiveness of the care provided. They conducted interviews with the relevant persons including senior management and staff, the allocated social workers and other relevant professionals. Wherever possible, inspectors will consult with children and parents. In addition, the inspectors try to determine what the centre knows about how well it is performing, how well it is doing and what improvements it can make.

Statements contained under each heading in this report are derived from collated evidence. Due to the emergence of Covid-19 this review inspection was carried out

with a blend of an onsite visit and through a review of documentation and a number of online interviews.

The inspectors would like to acknowledge the full co-operation of all those concerned with this centre and thank the young people, staff and management for their assistance throughout the inspection process

2. Findings with regard to registration matters

A draft inspection report was issued to the centre manager, director of services and the relevant social work departments on the 6th. The centre provider was required to provide both the corrective and preventive actions (CAPA) to the inspection service to ensure that any identified shortfalls were comprehensively addressed. The suitability and approval of the CAPA based action plan was used to inform the registration decision. The centre manager returned the report with a satisfactory completed action plan (CAPA) on the 3rd June 2021 and the inspection service received evidence of the issues addressed.

The findings of this report and assessment by the inspection service of the submitted action plan deem the centre to be continuing/ not continuing to operate in adherence to the regulatory frameworks and Standards in line with its registration. As such it is the decision of the Child and Family Agency to register this centre, ID Number: 023 without conditions from the 13th September 2019 until 13th September 2022 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 16 – Notification of Significant Events

Theme 3: Safe Care and Support

Standard 3.1 Each Child is safeguarded from abuse and neglect and their care and welfare is protected and promoted.

Inspectors found the centre was operating in compliance with the relevant policies and legislation as outlined in Children First: National Guidance for the Protection and Welfare of Children, 2017. There was a suite of policies and procedures in place which were updated in 2020. Further work was on-going at the time of inspection to align these policies with the individual themes of the National Standards for Children's Residential Centres, 2018 (HIQA).

Inspectors reviewed a sample of personnel files and found that policies in respect of vetting practices were adhered to and that they contained all the required verified references, qualifications and Garda vetting.

A child safeguarding statement dated March 2020 was in place and displayed appropriately. It contained a thorough risk assessment, policies, principles and procedures to keep young people safe as well as details of designated and deputy designated liaison persons. There was written confirmation from the Tusla Child Safeguarding Statement Compliance Unit that it met the required standard. Inspectors found that there were systems in place to monitor and audit compliance with child safeguarding policies and practices. A recent centre audit by the quality assurance and practice manager found that there could be better evidence of discussions relating to safeguarding and child protection at team meetings and inspectors concur with this finding. This issue was being actioned at the time of this inspection.

The inspectors examined the register of child protection concerns. There had been six referrals through the Tusla Portal and each of these had been followed up, managed appropriately and closed. There was evidence of collaborative approaches through meetings between social work, An Garda Síochána and the centre. Inspectors noted that some of these referrals lacked detail in that the name of a person alleged to have caused harm to young people was known to the care team but

omitted from these records. The centre manager must ensure that all relevant information is provided to Tusla when reporting matters of child protection.
A review of staff training records evidenced that each staff member had also completed the Tusla E-Learning module: Introduction to Children First, 2017. The organisation also provided a training module in respect of their child protection policies and procedures. All but one staff member (who was employed as a trainee currently studying for a social care qualification) were designated mandated persons under the Children First Act 2015. Inspectors found from interviews and questionnaires that the team were familiar with child protection reporting procedures and their statutory obligations. They named child protection and safeguarding policies guiding their practice, however they were less familiar with aspects of the professional code of conduct and this should be revisited at team meetings and through supervision.

There was a policy in place to address bullying, including cyber bullying in line with Children First, 2017 and relevant legislation. The child safeguarding statement included risks relating to on-line safety and procedures were implemented in collaboration with social workers to monitor the young people's use of the internet and social media if specific vulnerabilities were identified. The team were alert to issues of bullying and this issue was identified between young people in late 2020. Inspectors found that staff followed the centre policy and procedure and that prompt action was taken to address this issue quickly and mitigate any against any possible harm. Strategy meetings involving social workers and clinical supports were convened and risk assessments and safety plans were followed. Inspectors were provided with evidence of keyworking which took place with all young people involved. The social workers who spoke with inspectors and responded to inspection questionnaires were complementary about how this issue was handled.

Young people's social workers confirmed that they worked collaboratively with the centre to implement identified goals for young people. They were sent copies of significant events, risk assessments, safety plans and placement plans. Inspectors noted that updated care plans were not provided after child in care review meetings and that during 2020 there was no care plan on file for three of the young people despite the aims of the placement having changed in that time. While records of these meetings were available and it was evident that the social worker was very involved and supported both the placement and the families, care plans were not provided in line with regulations to inform placement planning in the centre. Inspectors found it difficult to make sense of aspects of child in care review meetings in the absence of the statutory care plan. There was evidence that the social care

manager had written to the supervising social work department to request care planning documents. The centre policy on care planning outlined an escalation procedure to the social work department which had commenced but had not yet been fully followed through to secure all relevant documentation. Inspectors noted too that a care plan for one young person could not be located following a child in care statutory review in March 2020 and the social work department informed the centre that they were following this up with a previous team.

There were agreed procedures to inform parents of any allegations of abuse either by the team or the supervising social workers depending on the circumstances. Inspectors found that appropriate records were maintained of all family and professional contacts.

There was evidence of strategies in place to support young people and to promote their safety. Review of placement plans evidenced that individual areas of vulnerability were identified for young people and that keyworking and individual work took place to support them and ensure their safety. Young people had age appropriate free time and where it was deemed necessary, supervised access to the internet.

A protected disclosures policy which was an addendum to the suite of policies and procedures was circulated to the staff team in January 2020 to facilitate raising concerns or disclosing information relating to poor practice. Inspectors found in interviews that staff members were familiar with the policy and would report any concerns without fear of adverse consequences. Staff stated in interview that internal and external management were available and approachable.

Standard 3.2 - Each child experiences care and support that promotes positive behaviour.

The centre had a policy in respect of care and control which placed an emphasis on young people's strengths and reinforcing positives rather than sanctioning negative behaviour. If sanctions were used they were related to the behaviour, there was an emphasis on learning and work took place with young people to ensure they understood why it was in place. Young people had the opportunity to earn back privileges when they engaged in restorative work.

All staff had received training in the recognised model of behaviour management and they were scheduled to receive an updated version of this programme in the weeks

after inspection. There were individual crisis management plans (ICMPs) in place to assist and support staff and the young people to manage difficult behaviour. These were being updated at the time of inspection to Individual Crisis Support Plans (ICSP's) in line with the revised version which placed a greater emphasis on the experience of trauma. Interviews with staff and review of records showed that the team were supported to recognise the underlying causes of behaviours of concern and there was evidence of regular review of ICMP/ICSP's. Social workers interviewed during the inspection stated that the team were consistent and stable, that they used relationships to support young people and this was evident through keyworking records and individual work.

During inspection interviews the staff team were generally aware of the impact of trauma, neglect and abuse and how these could impact the behaviours of young people. Inspectors found that there was guidance and direction from the organisation's two psychologists to support the team in their work with young people. However in one case, inspectors found that while multi-disciplinary meetings were taking place with input from the clinical team, the analysis and direction provided by the specialists were maintained on the minutes of meetings but were not fully reflected in their placement plan. There were differing and changing hypotheses relating to a specific behaviour and inspectors found from interview with staff and review of records that the team would benefit from greater clarity in relation to understanding of the possible causes of this behaviour. All necessary information was provided to facilitate effective management of behaviour. External advice and guidance to the team from the supervising social work department was provided to support them with one aspect of care provision for another young person.

One young person was available to meet inspectors. They stated they were very happy living in the centre and spoke highly of the support of the staff team. Review of the significant event register found that there were low levels of incidents in the centre. There was good evidence of strategy meetings and communication with all relevant people if issues such as bullying arose. Inspectors found that significant events were reviewed at team meetings and multidisciplinary meetings with the input of the person responsible for monitoring the implementation of the model of behaviour management.

There was a system in place to audit compliance with all national standards and this included review of behaviour management under theme three as had taken place by the quality assurance and practice manager recently. A small number of deficits highlighted in this report were not identified in this audit however inspectors found

it was generally a thorough process with a detailed and comprehensive report with clearly identified actions.

Each young person had an up to date individual absence management plan which was required under the *Children Missing from Care: A Joint protocol between An Garda Síochána and the Health Services Executive, Children and Family Services, 2012'*.

An addendum policy to the suite of policies and procedures in respect of the use of restrictive practices was provided to the staff team in January 2020. The centre had a register for each young person to record any restrictive practices in use. These included physical restraint, locking doors, locking chemicals away and restricting age rated games for young people. Practices such as restricting young people's phones, room searches and alarms when young people come out of their rooms at night were not considered restrictive practices and this should be reviewed. There had been no use of physical interventions in the 12 months prior to this inspection with the exception of one incident of staff breaking up a fight. Inspectors found that the individual ICMP/ICSP documents did not clearly record if there were any contra-indications to the use of restraint. Also, under floor heating was not factored as a risk consideration on these documents as is recommended in the model of behaviour management framework.

Standard 3.3 - Incidents are effectively identified, managed and reviewed in a timely manner and outcomes inform future practice.

Inspectors found that an open culture was promoted in the centre and staff members who were interviewed were confident that they would challenge each other's practice if required. The quality assurance and practice manager and operations manager had a regular presence in the centre and staff and young people were familiar with them.

There was evidence that the staff and management team were in regular contact and worked closely with social workers, guardians ad litem, and family members. Although there was no formal mechanism in place to receive feedback from social workers they confirmed to inspectors that they were often asked if they were satisfied with their experience of the care being provided. There was evidence that parents were involved in the care of their young people and the social care manager provided a form that was sent to parents to receive feedback about the care provided. This was under review at the time of inspection to ensure that it was effective in terms of informing service improvements.

The inspectors found that the centre had a written policy and procedure for the recording and notification of significant events. Supervising social workers confirmed that these were received in a timely manner and that there was excellent communication with the team and management. There was evidence that the social care manager and operations manager and clinical team had oversight of significant events that occurred in the centre.

There was evidence that reflective practice was encouraged in the centre and there was a policy in respect of debriefing staff. Inspectors found however, that while it was evident that significant events were routinely reviewed at team and MDT meetings there was no policy in respect of significant event review and this is recommended to ensure clarity and consistency of process. When this was highlighted the operations manager stated that one had recently been drafted following another inspection of the organisation and it was to be signed off and communicated to all staff as part of on-going policy review.

Compliance with Regulation	
Regulation met	**Regulation 16**

Compliance with standards	
Practices met the required standard	**Standard 3.3**
Practices met the required standard in some respects only	**Standard 3.1** **Standard 3.2**
Practices did not meet the required standard	**None Identified**

Actions required

- The centre manager must ensure that all relevant information is provided to Tusla when reporting matters of child protection.
- The registered proprietor must review the restrictive practice policy to ensure that all restrictive practices are agreed, understood and recorded and that there is routine review of any restrictive practices in use to ensure that they are required
- The registered proprietor must ensure that each ICMP/ICSP records if there are contraindications to the use of any physical interventions and that under floor heating is considered as a possible risk.

Regulation 6: Person in Charge
Regulation 7: Staffing

Theme 6: Responsive Workforce

Standard 6.1 - The registered provider plans, organises and manages the workforce to deliver child-centred, safe and effective care and support.

There was a policy on management and staffing which included robust policies and processes to support the recruitment, retention, support and training of staff. Inspectors found there were sufficient staff numbers to meet the needs of the young people and fulfil the stated purpose and function. There was a staffing complement of thirteen including the social care manager, deputy manager plus eleven social care workers four of whom worked 120 hours per month and three who worked 90 hours per month. Three dedicated relief staff members were available to ensure adequate cover for all types of leave. Three staff members covered a 24-hour sleepover shift and there was always a fourth person rostered to work a day shift. The young person who met with inspectors said that they liked all the staff team and they were there to help and support them. Social workers interviewed during inspection noted that the team was very stable and that staff turnover was low. They spoke highly of the support provided to the young people and also specifically of excellent work to support family reunification.

Inspectors found that workforce planning took place at a strategic and operational level. There were opportunities for staff to take their annual leave and arrangements were planned in advance for cover for all types of leave. There was a Covid-19 contingency plan dated April 2020 which took account of staffing considerations. This was also highlighted on the organisation's risk register.

There were measures in place to support maintaining a stable team which included personal accident cover, insurance, income protection, pension plans, maternity benefit, counselling, training opportunities, career progression, professional supervision and clinical support. Staff members who were interviewed during inspection stated that it was a positive place to work and that management were available to them.

There was an effective on call system in place to ensure guidance and support was available at evenings and weekends. The staff team stated that the designated on call

person was always available for advice and support. Staff members were familiar with the thresholds for its use, which included involving An Garda Síochána, serious property damage, young people missing in care, child protection concerns, risk or injury to young people, unexpected staff absences and complaints from parents. The policy stated that on call managers were the designated liaison persons outside of office hours. The policy covered handover of all relevant information and maintenance of on call records including decisions taken. Inspectors found the system was well established and utilised by the team in accordance with the criteria laid out within the policy.

Standard 6.2 - The registered provider recruits people with required competencies to manage and deliver child – centred, safe and effective care and support.

Inspectors found that with the exception of one staff who was appointed in 2018 and designated as a trainee all the team held social care qualifications. The three relief staff held social care, youth and community work and teaching degrees. Eight of the staff had worked in the centre prior to 2018 and the team had a range of experience in social care.

The centre manager was in this post since 2009. They held a relevant qualification and many years' experience in social care. Inspectors found that they demonstrated the competencies and skills required for the role and that staff and social workers were satisfied that the centre was well managed. The records reviewed provided good evidence of their governance and oversight of care provision in the centre.

Each staff member had a job description and contract for their current role. There was a copy of an employment contract on all staff files sampled by inspectors. A secure personnel file was held for each staff member. These were well organised and facilitated ease of access. There was evidence that these were subject to oversight and regular auditing through internal review and quality assurance processes.

Inspectors found that recruitment processes were in line with the organisation's HR policies, with relevant Irish and European legislation and the Department of Health circular in respect of recruitment and selection of staff to children's residential centres, 1994. Garda vetting had taken place and was in line with the National Vetting Bureau (Children's and Vulnerable Person's) Acts, 2012 – 2016. The staffing policy did not outline the frequency of staff being re vetted by An Garda Síochána and one file reviewed showed a gap of four years which is unacceptably high. This was

highlighted during an external audit of the service in March 2021 and measures were put in place to rectify this immediately. A review of a sample of staff files found verification of qualifications and references as required.

There was a written professional code of conduct contained within the child protection and safeguarding policies. Inspectors found that while some staff were aware of and could describe the content and its use in practice, others were less familiar and this should be reviewed.

Standard 6.3 The registered provider ensures that the residential centre supports and supervise their workforce in delivering child-centred, safe and effective care and support.

Inspectors found that there were effective systems in place to ensure that the centre was delivering child centred, safe and effective care and support including monthly management meetings, monthly clinical reviews, monthly checklists, quality assurance audits and external oversight. The policy also stated that the operations manager, clinical manager and quality assurance and practice manager met with the CEO every four weeks.

In general, there was evidence that staff were clear about the policies and procedures guiding their work. There were clear lines of accountability and reporting lines. Inspectors interviewed staff and management and reviewed team meeting records, young people's care files, supervision and other records. It was evident that the staff team were supported to exercise their professional judgment and were accountable for their work.

There were procedures in place to protect staff and minimise the risk to their safety. These included training in a recognised behaviour management programme, a robust on-call system, and a risk management framework. Each young person had an individual crisis management plan (ICMP/ICSP) to support staff manage challenging behaviour. Clinical advice was also available where required to support staff and there was evidence of this across young people's files. There was a culture of reflective practice where staff reviewed interventions and outcomes during their shifts.

Regular team meetings and multidisciplinary team meetings took place and a team-based approach to the care of young people was evident. Social workers and staff informed inspectors that there were effective communication systems to support a

consistent approach to the provision of care set out in young people's individual plans. Handover meetings took place on a daily basis which the manager attended regularly.

There was a supervision policy and process in place whereby staff members received formal supervision every four to six weeks. The manager and deputy manager who provided supervision to the team had received appropriate training. Staff members who spoke to inspectors and responded to questionnaires were satisfied with the supervision being provided. A review of a sample of supervision records found that with a small few exceptions, it was taking place in line with centre policy. If delayed by annual leave or other circumstances it was immediately rescheduled. Each staff member had a supervision agreement and there was evidence that planning for care, therapeutic supports, training and team dynamics were discussed amongst other topics to support staff. Supervision records sampled evidenced that the team welcomed feedback on their work practice. The centre's supervision policy did not set out a requirement for supervisee training and it is recommended that an overview of the model of supervision in use and the functions of supervision are included in the policy and provided to the team through induction or supervision. The operations manager informed inspectors that this was being drafted following feedback from another recent inspection in the organisation and would be communicated to staff teams as part of on-going policy review.

Staff appraisals were taking place annually since March 2020. Inspectors found that this process and template in use could be improved to facilitate more effective review of the work and setting goals with individual staff members. The process requires a better focus on professional development and should set out an action plan with timeframes and who is responsible for actions agreed.

There were systems in place to support staff to manage the impact of working in the centre. These included, availability of a counselling service, professional supervision, debriefing and reflective practice. The clinical psychologists were available for staff consultation and support if required.

Standard 6.4 Training and continuous professional development is provided to staff to deliver child-centred, safe and effective care and support.

Inspectors found that staff members received induction into the centre's policies and procedures and they were confident in describing these during inspection interviews.

There was evidence policies were updated or devised as required that these were communicated to staff discussed at reviewed both at team and in supervision.

Mandatory training for staff included child protection, training in a recognised model of behaviour management, fire safety, first aid. Although the induction policy did not state that training would be provided in the organisation's model of care there was evidence that this was provided upon commencement of employment. It is recommended that the policy is revised to ensure clarity.

Inspectors found that staff were encouraged and supported to attend additional training in support of their work although staff appraisals required a greater focus on training and development. Workshops which were organised by the social work departments to support approaches to care for individual young people were valued by the staff team. There was evidence that the clinical team provided resources and information to support the team with specific approaches or issues. Training needs were identified through staff supervision, at team meetings during planning meetings for young people. Inspectors found that training had been impacted by the Covid-19 pandemic and that some supplementary training had been postponed or cancelled. Only some staff files reviewed contained evidence of training supplementary to the mandatory training required upon induction.

The organisations induction policy described a one day induction by the HR department followed by regular and in service training and there was evidence of this on the sample of staff files reviewed during inspection.

There was a training schedule for 2021 however this was mainly focused on mandatory training. A training needs analysis provided for 2021 only included mandatory training and this must be reviewed to link to the care of young people, staff supervision and appraisals to ensure a proactive approach to professional development.

There was an effective system to record and track all training provided and records were kept of all training that staff completed. They were reminded when core or refresher training was due and were scheduled and supported with protected time to attend required courses.

Compliance with Regulation	
Regulation met	**Regulation 6** **Regulation 7**
Regulation not met	**None Identified**

Compliance with standards	
Practices met the required standard	**Standard 6.1**
Practices met the required standard in some respects only	**Standard 6.2** **Standard 6.3** **Standard 6.4**
Practices did not meet the required standard	**None Identified**

Actions required

- The registered proprietor must ensure that all staff are familiar the professional code of conduct.
- The registered proprietor must ensure that appraisal policy and process has an appropriate focus on professional development.
- The registered proprietor must ensure that there is a specific training needs analysis for the centre which is linked to the care of young people, staff supervision and appraisals to ensure a proactive approach to professional development.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
3	The centre manager must ensure that all relevant information is provided to Tusla when reporting matters of child protection.	Completed. Reviewed with the care team at team meeting on 28/04/21. All relevant information will be provided to Tusla when reporting matters of Child Protection. Immediate and on-going.	Centre management and senior management will monitor the reporting of all child protection matters and ensure that all relevant information is provided to Tusla as required
	The registered proprietor must review the restrictive practice policy to ensure that all restrictive practices are agreed, understood and recorded and that there is routine review of any restrictive practices in use to ensure that they are required	Registered provider will review restrictive practice policies at senior management meeting scheduled for 27/05/21.	Senior and centre management will monitor the use of restrictive practices in the centre to ensure that they are agreed, understood and appropriately recorded. This will be routinely reviewed.
	The registered proprietor must ensure that each ICMP/ICSP records if there are contraindications to the use of any physical interventions and that under floor heating is considered as a possible risk.	Completed. ICMP/ICSP have been reviewed and updated to record any contraindications to the use of restraint/physical interventions. Under floor heating has been added to the centre's risk register.	Senior and centre management will monitor ICMP/ICSP to ensure that they continue to record any contra-indicators to the use of physical interventions.

6	The registered proprietor must ensure that all staff are familiar the professional code of conduct. The registered proprietor must ensure that appraisal policy and process has an appropriate focus on professional development. The registered proprietor must ensure that there is a specific training needs analysis for the centre which is linked to the care of young people, staff supervision and appraisals to ensure a proactive approach to professional development	Completed. Reviewed by centre management with the care team on 28/04/21. Immediate and on-going. The appraisal policy and process is due to be reviewed on 27/05/21 with senior management. Completed. Centre management reviewed the training needs analysis on 01/05/21. Training needs and resources required will be brought to senior management for consideration.	Senior and centre management will ensure that the code of conduct is regularly reviewed at team meetings. Senior and centre management will ensure that the revised appraisal policy has an appropriate focus on professional development of the staff team. Senior and centre management will review the training requirements for the centre on an on-going basis.