Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Adults)

Issued by the Chief Inspector

Name of designated centre:	Centre 5 - Cheeverstown Community Services (Hillcrest/Ballyroan)
Name of provider:	Cheeverstown House CLG
Address of centre:	Dublin 6w
Type of inspection:	Announced
Date of inspection:	14 January 2020
Centre ID:	OSV-0003556
Fieldwork ID:	MON-0027574

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

This designated centre comprises of three two storey community residential houses, all located between two towns in Co. Dublin. The centre provides care and support to men and women with intellectual disabilities over the age of eighteen. The designated centre has capacity for 11 individuals in total. House one can provide full-time residential care for three male individuals. The house consists of four bedrooms with one bedroom having an en-suite bathroom, and a further shared bathroom and additional toilet facilities downstairs. There is a kitchen, dining room and sitting room with a garden area out the back. House two can provide residential care between Monday and Friday for three female individuals. The house consists of four bedrooms, a dining room, a kitchen and sitting room. One bedroom has an en-suite bathroom and there is a shared toilet and shower upstairs and a downstairs toilet. House three can provide full-time residential care for five individuals. The house consists of seven bedrooms, a kitchen/dining area and a sitting room. There are two bathroom/shower rooms with toilets upstairs including a downstairs toilet. There is a garden area out the back. There is transport available on request for all houses. The person in charge shares their working hours between the three houses within the designated centre. There are staff nurses, social care workers and core support staff and resource staff employed in this centre to support the residents.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	9

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended. To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
14 January 2020	09:45hrs to 22:00hrs	Jacqueline Joynt	Lead

What residents told us and what inspectors observed

On the afternoon of the inspection the inspector met with seven of the nine residents living in the three houses in this designated centre. During these engagements some of the residents relayed their views to the inspector and where appropriate staff supported communication between residents and the inspector so that residents' views could be known. Residents' views were also taken from observations, Health Information and Quality Authority (HIQA) questionnaires, minutes of residents' meetings and various other records that endeavoured to voice the residents' opinions.

A number of residents advised through the HIQA questionnaires that they were happy with the overall choice they were provided and that they were happy with mealtimes and food provided in the centre; one resident advised that they were diabetic and were very happy that their meals were always on time. Residents also advised that they were happy with the personal space provided to them such as their bedrooms; residents in two of the houses were happy to show the inspector around their rooms and appeared content and proud while doing so. Residents also relayed that they were happy with the activities available to them; some of the residents talked to the inspector about the different community activities they enjoyed such as bowling, dog walking and their employment in local businesses.

Residents advised that they were happy with the care and support provided by staff and that they found staff were easy to talk to, staff listened to them and overall were familiar with their likes and dislikes. However, a number of feedback forms suggested a lack of continuity of care; for example one resident advised they would like more regular staff nurses to help them with their routine, another resident commented that they "would like to have regular staff".

Furthermore, not all family members were happy with the consistency or continuity of staffing in the centre and relayed to the inspector that they felt there were a lot of different staff working in the centre. They advised that staff were not always familiar with their family members' needs and that this had on occasion resulted in negative outcomes for them. However, when referring to a staff member who was employed on a consistent basis over the past year, the feedback was very positive about the relationship that had been built with their family member and how it resulted in many positive outcomes for the resident.

Residents who spoke with the inspector informed them that they knew who they could go to should they wish to make a complaint and most feedback forms relayed the same information. However, not all residents were happy with the way their complaint was dealt with; for example a resident's questionnaire noted that they had made a complaint in relation to "more staff needed" and that they were not happy with how the complaint was dealt with.

On the day of inspection the inspector observed that the staff working with the

residents were staff members who work in the centre on a permanent basis. The inspector saw that they were very familiar of the residents needs and supports required to meet those needs. The residents appeared relaxed and comfortable in the company of staff in each of the houses. The inspector observed that there was an atmosphere of friendliness throughout the three houses in the centre and that staff were kind and respectful towards the residents through positive, mindful and caring interactions.

Capacity and capability

The inspector found that the registered provider and the person in charge endeavoured to ensure that a safe and good quality service was provided to residents. The inspector found evidence to demonstrate that there had been a number of improvements in the designated centre since the last inspection and overall, the majority of actions required had been completed. Over the last three years there has been continuous progression and improvements made to the overarching systems relating to centre's workforce including staff compliment and staff training and supervision, however on the day of inspection the inspector found that further improvements relating to the centre's workforce were required.

The inspector reviewed a sample of staff files to ensure they were in line with the required information and documents specified in Schedule 2 and found that for the most part the required information was included in all files. However, in relation to Garda vetting and in line with the organisation's Garda vetting policy, the inspector found improvements were warranted to ensure all staff Garda vetting was up-to-date.

The inspector found that despite the on-going work by the provider to ensure a full cohort of staff as per the centre's statement of purpose the inspector found that the whole time approved staffing was not in place and that this had resulted in a high dependency on relief staff in all three houses.

The inspector saw that due to the over-reliance of relief staff in the centre there was a lack of continuity of staffing and that this often hindered the promotion of continuity of support and development and maintenance of relationships. On the day of inspection the inspector was advised by family and staff members how the lack of continuity of staffing resulted in negative outcomes for residents; for example when a resident was not familiar with their staff they generally refused to engage in any activities. Furthermore, where strategies had been set up to support a resident engage in healthy eating habits, these often lapsed due to lack of consistency and continuity of staffing.

The inspector reviewed twelve weeks of rosters for each of the three houses and found that on a weekly basis, in two of the houses there was more relief staff

employed than permanent (or contracted) staff. Despite a number of relief staff working several shifts through-out the twelve week roster overall, relief staff were not employed on a regular enough basis to ensure continuity of care or time to develop or build therapeutic relationships with all residents. The inspector found that a review of staffing levels per house was required; for example the approved number of whole time equivalent staff for one of the houses suggested that regardless of employing a full cohort of permanent staff in the house, a high number of relief staff would still be required.

For the most part, governance systems in place provided assurances that service delivery was safe and effective through ongoing auditing and monitoring of the centre's performance. The provider had ensured that an annual review of the quality and safety of care and support in the centre had been completed. The inspector saw that the residents and their representatives had been consulted as part of the review. Furthermore, an unannounced six monthly review by the registered provided on the safety and quality of care and support provided in the centre had been completed and included a clear action plan, including appropriate time-lines for the necessary improvements to be carried out.

The service was lead by a capable person in charge however, improvements were required to ensure that the person in charge was supported fully by the registered provider to ensure appropriate oversight of service delivery. The person in charges' hours were included on the staff roster however, did not relay which house they were assigned to on a daily basis. Primarily the person in charge was working from a location that was not part of the designated centre and on review of documentation it was found that overall, the person in charge's onsite presence in the designated centre was insufficient to ensure adequate oversight. Overall, the inspector found that a review was warranted of the person in charge's current role, including their on-site hours in the designated centre, to ensure the effective governance, operational management and administration of the designated centre.

A needs based training analysis had been carried out to assess training needs of staff to enabled them provide care that reflected up-to-date, evidence-based practice. The inspector found that while the organisation's mandatory training had been provided to the majority of staff, not all staff had been provided with training that related to the specific needs of all residents.

One to one supervision meetings alongside performance management meetings were taking place to support staff perform their duties to the best of their ability. However, the inspector found that improvements were required to ensure the frequency of these meetings were in line with the centre's policies and procedures. Furthermore, the inspector found that the supervision support system in place for relief staff members required reviewing to ensure that it was pertinent to the relief staffs' role and responsibilities.

Throughout the day the inspector observed kind and caring interactions between staff and residents. The inspector had a number of brief conversations with the staff on duty that day and found that staff demonstrated good understanding of the

residents' needs and endeavoured to ensure that they were met in practice.

The person in charge was submitting notifications regarding adverse incidents within the three working days as set out in the regulations. The person in charge had also ensured that quarterly and six-monthly notifications were being submitted as set out in the regulations.

Registration Regulation 5: Application for registration or renewal of registration

The application for registration renewal was submitted to the Office of the Chief Inspector within the required time-frame. However, not all required Schedule 2 information had been submitted accurately or adequately. Follow up confirmation regarding the leases for two of the houses was required to ensure security of tenure was in place for all residents.

Judgment: Substantially compliant

Regulation 15: Staffing

The inspector saw that there was an over-reliance on relief staff in the centre. There was a lack of continuity of staffing and that this often hindered the promotion of continuity of support and development and maintenance of relationships.

Approved whole-time equivalent numbers of staff for the centre required reviewing to ensure the reduction of relief staff.

The person in charges' hours were included on the staff roster however, did not relay which house they were assigned to on a daily basis.

Not all Schedule 2 requirements were in place for all staff; for example Garda vetting requirements.

Judgment: Not compliant

Regulation 16: Training and staff development

For the most part staff were provided with the organisation's mandatory training however, not all staff were provided with training to meet the specific needs of residents; although general guidance had been provided to staff regarding Dysphagia and Cystic Fibrosis no formal training had been provided.

Furthermore, the inspector found that not all relief staff had been provided with training to meet the specific needs of all residents; for example training on epilepsy, autism, diabetes and manual signing systems.

The inspector found that there had been marked improvements to the provision of one to one supervision meetings to staff over the past two years however, further improvements were required to ensure that the regularity of meetings were in line with the organisation's supervision policy. Furthermore, the inspector found that improvements were required to the supervision support system in place for relief staff to ensure it was pertinent to their role and responsibilities.

Judgment: Substantially compliant

Regulation 22: Insurance

The registered provider had valid insurance cover for the centre, in line with the requirements of the regulation.

Judgment: Compliant

Regulation 23: Governance and management

The annual report and unannounced six monthly reviews were being carried out in line with regulation.

However, the inspector found that a review of the person in charge's current role, including on-site hours in the designated centre, was warranted to ensure the effective governance, operational management and administration of the designated centre.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The statement of purpose contained all required information, as per Schedule 1.

Judgment: Compliant

Regulation 4: Written policies and procedures

Not all written policies and procedures were up-to-date however, the inspector saw that since the last inspection a lot of work had been completed on the centre's Schedule 5 policies and procedures with many at the final stages of review.

Judgment: Substantially compliant

Quality and safety

The inspector found that overall, the centre provided a homely and pleasant environment for residents and that for the most part residents' well-being and welfare was maintained by a good standard of care and support. It was evident that the person in charge was aware of residents' needs and knowledgeable in the care practices required to meet those needs. However, on the day of inspection the inspector found that improvements were required to ensure that all quality and safety regulations were fully compliant.

The inspector sampled a number of residents' personal plans and found that overall residents' plans had been reviewed annually and that the reviews were in consultation with the residents, their keyworker and where appropriate, family members. However, the inspector found that there were gaps in documentation surrounding some residents' goals and the progress of their goals. Furthermore, not all residents' personal plans were provided in a format which were accessible to the resident. These improvements had been noted on the last inspection and on the day of inspection remained outstanding.

For the most part all residents were facilitated to exercise choice across a range of therapeutic and social activities and to have their choices and decisions respected. The inspector found that residents were assisted to exercise their right to experience a range of relationships, including friendships and community links, as well as personal relationships. Residents were engaged in their local community through many different social activities such as shopping, bowling, basket ball, attending and participating in local religious services, attending local football matches and enjoying treatments at the local beauticians.

The inspector saw that residents were supported to choose goals that encouraged their independence and personal development. A resident advised the inspector about an overnight holiday abroad which they went on with a local social group. Another resident told the inspector about their job in a local business and on the evening of the inspection, the inspector spoke with a resident who was very proud and excited about attending their graduation for a course they had just recently completed.

The inspector found that overall, residents were protected by practices that promoted their safety. Staff facilitated a supportive environment which enabled the residents to feel safe and protected from abuse. On the day of the inspection there was an atmosphere of friendliness, and on review of personal care plans and through observations, the residents' modesty and privacy was observed to be respected.

However, there had been a noted increase of alleged safeguarding incidents reported to HIQA over the last six months from the centre. On review of documentation submitted post inspection, the inspector found that there had been a satisfactory level of scrutiny by the registered provider of the alleged incidents to guarantee that safeguarding arrangements in place ensured residents' safety and welfare. The inspector found that although none of the allegations were upheld, a number of the alleged incidents highlighted the impact lack of continuity of staffing can have; for example one incident occurred where a staff member was not fully familiar with a resident's routine, and another incident occurred where a staff member was unfamiliar on how to respond in an appropriate manner to a resident's behaviour. The inspector found that where outcomes of investigations required increased support, supervision and further training that this had been provided to the associated staff members.

The inspector found that the design and layout of the premises ensured that the residents could enjoy living in a comfortable and homely environment. Residents expressed themselves through their personalised living spaces. The residents were consulted in the décor of their rooms which included family photographs, residents' paintings and memorabilia that were of interest to them. All three houses were found to be cleaned to a high standard. The inspector observed that many improvements to the decorative and structure of the three houses had taken place with most houses being freshly painted. Some actions from the last inspection remained outstanding; the inspector saw that these had been addressed on the centre's annual review and were included on the centre's current maintenance log however, the inspector found to ensure the effectiveness of the maintenance log, timelines were warranted.

Regulation 13: General welfare and development

Overall, the inspector found that residents were assisted to exercise their right to experience a range of relationships, including friendships and community links, as well as personal relationships.

Judgment: Compliant

Regulation 17: Premises

The three houses were found to be suitable to meet residents' individual and collective needs in a comfortable and homely way. This enabled the promotion of independence, recreation and leisure and enabled a good quality of life for the residents in the house. Overall, the physical environment of the three houses were clean and in good decorative and structural repair.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The inspector found that residents were provided with a personal plan that was reviewed annually however, there were some gaps in the documentation that did not result in a medium to high risk to the residents. For example there were gaps relating to residents' social and personal goals including progress and timelines of the goals.

The inspector found that a number of residents were not provided with an accessible format of their personal plan so that the plan could be easily understood by the resident.

Judgment: Substantially compliant

Regulation 8: Protection

The inspector found that despite an increase in alleged safeguarding incidents reported by the centre that there was an adequate level of scrutiny and oversight by the registered provider to guarantee that safeguarding arrangements in place ensured residents' safety and welfare.

Judgment: Compliant

Regulation 9: Residents' rights

The inspector observed that overall the registered provider endeavoured to promote the rights of the residents. This was being highlighted in the weekly resident meetings. Residents had been supported to understand their right to make a complaint. There was evidence of residents being supported to choose activities

through the use of visual aid choice boards. The inspector observed that the residents were being supported to set personal goals with their keyworkers. There was also information on how to access an independent advocate available to residents on the centres notice board.
Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Substantially compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Centre 5 - Cheeverstown Community Services (Hillcrest/Ballyroan) OSV-0003556

Inspection ID: MON-0027574

Date of inspection: 14/01/2020

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Registration Regulation 5: Application for registration or renewal of registration	Substantially Compliant
Outline how you are going to come into compliance with Registration Regulation 5: Application for registration or renewal of registration: Confirmation from CEO of housing agency regarding security of tenure for one location submitted by RPR to inspector on 03/02/2020. Housing agency has reissued lease for other location showing 4 year duration. Residents supported to understand and sign own tenancy agreement. Meeting with housing officer on 04/02/2020. Tenancy agreements to be signed by residents by 28/02/2020	
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: All schedule 2 documents are now on file for each staff member of DC5 To reduce the use of relief staff, the 0.5wte real time vacancy has been re-advertised with the intention of bringing a regular staff to contract to provide continuity of support. The allocated staffing supports will be reviewed by PIC and PPIM to ensure they are based on assessed needs of residents and if gaps are identified then application will be made for consideration of an increase in budgetary allocation. To ensure evidence of effective governance of the designated centre the roster will reflect presence of PIC when in each location. 27/03/2020	

Regulation 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
Training needs analysis for core support staff completed by PIC with Support Team Manager.
Gaps in DC5 staff non – mandatory training needs have been identified. EDS training scheduled during March 2020.
Training on cystic fibrosis currently under review and plan to schedule same in April 2020
Core support team members will access non mandatory training specific to the needs of residents in DC5.
Schedule of supervision sessions with core support team members during 2020 has been issued by Support Team Manager.

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
To ensure effective governance and the operational management the roster will reflect the presence of PIC's on site hours in the designated centre locations 27/03/2020

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
The PPPG committee has scheduled the review of each policy that is out of date. Review of all schedule 5 policies will be completed by July 2020

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
Staff will be supported by the PIC and Quality team to ensure all documentation within the personal plan reflects the progress on goals achievement, and clearly documents the evaluation and review process.

The PIC will support the person and staff to design and document an accessible version of their plan using a system that reflects the person's communication style and is easily understood by the person.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Registration Regulation 5(2)	A person seeking to renew the registration of a designated centre shall make an application for the renewal of registration to the chief inspector in the form determined by the chief inspector and shall include the information set out in Schedule 2.	Substantially Compliant	Yellow	28/02/2020
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	31/03/2020
Regulation 15(3)	The registered provider shall	Not Compliant	Orange	31/03/2020

	ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.			
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	27/03/2020
Regulation 15(5)	The person in charge shall ensure that he or she has obtained in respect of all staff the information and documents specified in Schedule 2.	Substantially Compliant	Yellow	05/01/2020
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	29/05/2020
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/03/2020
Regulation 23(1)(c)	The registered provider shall	Substantially Compliant	Yellow	28/02/2020

	ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the chief inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Substantially Compliant	Yellow	31/07/2020
Regulation 05(5)	The person in charge shall make the personal plan available, in an accessible format, to the resident and, where appropriate, his or her representative.	Substantially Compliant	Yellow	27/03/2020
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall	Substantially Compliant	Yellow	24/04/2020

	assess the effectiveness of the plan.			
Regulation 05(7)(c)	The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include the names of those responsible for pursuing objectives in the plan within agreed timescales.	Substantially Compliant	Yellow	03/04/2020