Statement of Purpose

Regulation 3. Conditions of registration: general of the Regulation of Care (Standards and Requirements) (Jersey) Regulations 2018, requires providers to submit a Statement of Purpose for each service within an organisation. Please submit this form as part of your registration application or upon request by the Care Commission (if registration has transferred). You must inform the Care Commission of any changes to your Statement of Purpose within 28 days.

1. Provider information		
Name	Family Nursing & Home Care (FNHC) Rapid Response and Reablement	
Address of Provider	Le Bas Centre St Saviours Road St Helier	
Legal status of service	Family Nursing and Home Care (Jersey) Incorporated is an organisation incorporated in primary statute under the Family Nursing Services and Jersey Home Helps (Amalgamation) (Jersey) Law 1993	
2. Service information		
Service type	Care Home (adults)	☐
	Care Home (children/young people)	☐
	Day Care	☐
	Home Care	☒
Name of Service	Rapid Response and Reablement	
Address of Service	Le Bas Centre St Saviours Road St Helier Jersey	
Manager of the service	Clare Stewart	
Location of the service	FNHC Office Based at Les Bas, RRRT Island wide in patients home	

3. Categories of Care Provided					
Old age	☐		Substance misuse (drugs and/or alcohol)	☐	
Dementia care	☐		Homelessness	☐	
Physical disability	☐		Domestic violence	☐	
Learning disability	☐		Children (under 18)	☐	
Autism	☐		Other (please specify) Nursing care – includes all the categories above excluding children	☒	
Mental Health	☐				
Age ranges:	*18 and above*				
Types of Care	Nursing care Personal care Personal support	☒ ☐ ☐	*Refer to definitions in Regulation of Care (Jersey) Law 2014*		
4a. Accommodation Services					
Total number of beds	**NA**				
Total number of bedrooms	**NA**				
Number of nursing care beds	**NA**				
Number of personal care/support beds	**NA**				
4b. Home care services					
Size of home care service	Small (less than 112 care hours per week)	☐			
	Medium (112-600 care hours per week)	☒			
	Medium plus (600-2250 care hours per week)	☐			
	Large (2250 + hours per week)	☐			
Number of hours of care delivered	Detail the average number of care hours delivered per week: 193 Detail the maximum number of care hours the service can provide: 300 Nursing care hours are dependent on demand and capacity within the service which fluctuate according to patients nursing needs and acuity Additional 0hrs contract staff are available.				

	Available hours includes mandatory and essential training , planned and unplanned leave and non-patient contact time
4c. Day Care Services	
Maximum number of people using the service at one time	**NA**

4. Aims and objectives of the service

The aim of the Rapid Response and Reablement team (RRRT) is to deliver a safe, sustainable, and affordable service that is able to respond to the changing demographics and changing expectations of the population of Jersey. It incorporates the use of modern technologies and treatments, promotes and ensures people will have increased independence, and the choice of being cared for within their own home for as long as possible.

RRRT sets out an approach to the delivery of community based services and the development of the service will need to take into account the wider developments of Long Term Conditions, the future hospital plan, Sustainability of Primary care, Mental Health Strategy and the development of End of Life services. The service is adaptable and flexible to meet the needs of a health service undergoing significant redesign. The model in Jersey is an amalgamation of several UK models that allows a more flexible approach to care delivery and can adapt to change to meet the new demands on service providers.

The Jersey model is based, but not a replica of models in the UK, including Virtual Ward Hospital at home and follows the principles of the National Audit of intermediate care.

Links:

https://www.kingsfund.org.uk/sites/default/files/field/field_document/PARR-croydon-pct-case-study.pdf

https://www.nuffieldtrust.org.uk/research/do-virtual-wards-reduce-rates-of-unplanned-hospital-admissions-and-at-what-cost-a-research-protocol-using-propensity-matched-con

https://www.gov.uk/guidance/moving-healthcare-closer-to-home

https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/resources/emerging-practice

http://www.hospitalathome.org/about-us/how-it-works.php

https://www.nhsbenchmarking.nhs.uk/naic

The aims of the service:-

- To avoid a hospital admission
- To support and facilitate hospital transfers of care to the community
- To avoid premature long term admission to care homes
- To provide cost effective care
- To have a service which provides the right service first time
- To provide brief and timely support to care homes

https://www.fnhc.org.je/media/43133/strategy-2019-to-2023.pdf

Care is person centered and includes mental as well as physical health needs, delivered by a range of professionals through an Integrated Multi-Disciplinary Team (MDT) and the focus is on achieving agreed outcomes for both individuals and for the system as a whole. It fosters a culture of independence, delay or reduce hospital admissions and the need for long term care in care homes

The RRRT will work with the medical lead/GP to prevent admission in acute illness and agree a management plan with the patient, which may include admission to hospital if the person's needs cannot be safely managed or stabilized in their own home.

The RRRT provides practical help at home, where required, with personal care and actives of daily living during the acute/crisis care period to support the individual and their usual carers to maintain maximum independence and wellbeing. This is within the context of a reablement model with agreed, goal setting and opportunities to educate patients and their carers on how to avoid or reduce acute exacerbations of their condition and by promoting self-care, independence and wellbeing.

Management of the safety of patients and team capacity is by titrating the patients' needs based on clinical risk management using the Red Amber Green (RAG) acuity tool and available resources.

The integrated service has the ability to:-

- Receive referrals from Health Care Professionals and people working in the community who need urgent access to support for an individual
- Give accurate real time information and advice about urgent care options
- Provide rapid assessment of need and put safe and effective services in place to enable a person to be cared for at home or in a community setting during a short period of ill health or instability
- Support community based practitioners who identify that someone is reaching crisis point or deteriorating
- Capture information to support the future commissioning of community based services by evidencing demand and capacity across the whole system

The service consists of the following features:

- A multidisciplinary team consisting of the right mix of clinicians, professionals and support staff to work as a single Integrated Multidisciplinary Team to meet the needs of the client group

- Provide rapid assessment to determine the care a person needs during a period of ill health or instability
- The team provides integrated, person-centred, evidence-based care in the community for people who are deemed to be at risk of an unplanned hospital or care home admission due to an injury or an escalating health condition.
- The team have a varied skill mix including advanced clinical skills to support ambulatory sensitive conditions such as, but not exclusively, IV Therapy, COPD and Cellulitis, to ensure maximum opportunity to divert hospital admissions, mild and moderate mental health problems including dementia. Specialist teams are utilised to support RRRT within the community through Integrated Care Pathways.
- The team have the skills to provide a consistent, responsive homecare reablement service which supports people to maximise their independence, health and well being
- The team have specialist mental health nurses and support staff with skills to ensure that adults and older adults with complex needs can fully benefit from Rapid Response and Reablement Services
- The team are available to deliver 13 hours per day intensive/acute care support for approximately 1 and 3 days for Rapid Response episodes of care and between 1 and 5 days for Crisis support and up to a maximum of 4 weeks for reablement episodes of care /development programmes
- The team assess RRRT patients on an individual basis and determine and provide a voluntary on call cover to monitor/care overnight if required
- The team have had the relevant education and training which assures community and hospital based referrers that patients cared for in home settings are cared for by staff that not only provide high quality evidenced based care, but also have the competencies to know when to call for other help appropriately
- The team have the responsibility and authority delegated to the right person to work with the patient, not based on organisational boundaries
- Utilise risk stratification /Early identification of people with multiple admissions
- The team have the right equipment to support diagnosis in the community
- The team utilise and explore further possibilities for the use of assistive technologies to support people at home
- For those people needing ongoing support, the team provide an outcome-based support plan as the basis for facilitating support in the independent sector

Prevention of Admission /Early Transfer of Care (Discharge)
The RRRT is available 13 hours per days 7 days a week, 365 days per year.
It is designed to be able to respond promptly to acute, crisis and reablement episodes of care that do not require hospital admission.

The RRRT is for people with a clinical need (and may have a social need also) and will provide support from 72 hours up to a maximum of 6 weeks along the continuum of care with the aim of stabilizing the persons clinical needs and re enabling them to optimum independence . The support provided takes into account the person's social circumstances and available network of support in

their home environment. If the person's needs cannot be safely managed or stabilized, the person is transferred to hospital.

6. Range of Care Needs Supported

RRRT is available to any Islander 18 or over identified by a health and social care professional as someone who would benefit from the service and is experiencing an acute episode of illness, a crisis or requires reablement intervention. The service is available to all eligible adults irrespective of race, gender, disability or sexual orientation.

Access for people with sensory impairment and/or physical disability The team visits people in their own homes therefore enabling easy access to the service for people with disabilities. Where patients have a sensory impairment, the provider will ensure appropriate resources are made available to support their needs.

Access for non-English speaking Jersey residents
Where a patient's first language is not English, or where a patient has a communication difficulty, the provider ensures appropriate resources are made available to support their needs

Visitors to the island
Referrals for care for visitors are accepted by RRRT however they must have a Jersey General Hospital (JGH) medical / surgical physician who is taking medical responsibility for the client during the care episode. For visitors' emergency care, RRRT will refer to the JGH.

Referrals will be dealt with via a single point of access and agreed referral criteria.
Referrals will be accepted directly from:

- Any health care professional

7. How the service is provided

Referrals are accepted by telephone and accepted between 07:30 hrs and 18:00 hrs, 7 days per week.
The response times for patients waiting for RRRT is between 2 and 24 hours. The response required will be determined by the receiving coordinator and the level of care required, following review of the referral information and discussion with the referrer if appropriate.

Response times vary dependent on need:
Acute (level 1) 2 hour response
Crisis (Level 2) 2 hour response
Reablement (level 3) 24 hour response.

For the clarity of level of care need the following definitions have been adopted which have been drawn from the World health Organisation (WHO, 2013) and National Audit of Intermediate Care. (NAIC, (2015)

Acute level 1 - Acute care include all promotive, preventive, curative, rehabilitative or palliative actions, whether orientated to individuals or populations whose primary purpose is to improve health and whose effectiveness largely depends on time sensitive and frequently rapid intervention (WHO, 2013)
RRRT specific is 2 hour response with 72 hours intervention.

Crisis Level 2- Assessment and short term interventions to avoid hospital admission
Services with an expected, standard response time of less than four hours.
Interventions for the majority of service users will typically be short (less than 48 hours) but may last up to a week (NAIC, 2015)
RRRT specific is 2 hour response with 5 days intervention**.**

Reablement Level 3 - Helping people recover skills and confidence to live at home, maximizing their level of independence so that their need for on going homecare support can be appropriately minimized. Interventions for the majority of service users will last up to six weeks, though there will be individual exceptions. (NAIC, 2015)
RRRT specific is within 24 hours response with up to 4 weeks intervention

LIMITS – exclusion add in the template for inclusion / exclusion

RRRT treats all referrals accepted for assessment the same until the assessment and management plan is decided, based on the findings from the first review. The outcome of the initial assessment will determine ongoing management and will confirm if the patient is to remain at home or be admitted to either the general hospital, mental health unit, Step-up bed in the community or respite.

Assessment of Care - It is expected that grade 5 and above nurses will undertake the initial nursing assessments, and the occupational therapist, physiotherapist or re-ablement support worker will undertake assessments on re-ablement patients. This assessment will take place once a referral is received and reviewed. The client, patient consent must have been gained prior to referral. The assessment can be within JGH or the patient's home. The Clinical Co-ordinator for the team is responsible for triaging all referrals and scheduling the appropriately skilled staff member to visit the patient.

Professional judgement is exercised when determining the assessment templates to be completed during the first assessment however this data should comprise as a minimum:

- Initial Clerking assessment (Level specific)
- Audit documentation

- Any identified / necessary risk assessments specific to client
- Pre admission outcome measures
- Re-ablement only – Therapy outcome measures (TOMS)

The content of the supplementary hard copy record will contain core documents which includes NEWS score and demographic data but must also include any patient specific documents.

If it has not been possible to complete the admission process during the initial visit, it must be handed over to the co-ordinator, documented on EMIS, the white board and discussed at handover with a clear plan put in place for its completion.

The nurse or therapist will develop a management plan for the identified care / reablement needs and re affirm consent for care. The management plan and ongoing interventions are made in partnership with the patient and where appropriate, family/carer. Visits required are discussed and agreed. Subsequent visits are determined by progress of patients on the caseload and allocated each day following handover with the allocated co-ordinator.

Discharge planning commences at the admission stage and part of the assessment will be identifying and agreeing an estimated date of discharge from the service and this is recorded on the white board.

If the patient has pressure ulcer identified, an ASSURE incident report should be completed and the relevant documents would need to be completed.

If patient has a risk of falling a therapist will review them using a falls risk assessment, the Falls Risk Assessment Tool (FRAT)

If a patient has a fall whilst under the care of the RRRT team this is recorded on ASSURE. Ongoing referrals may be required but are determined following assessment within RRRT.

If a patient is accepted onto the caseload following initial assessment then a management plan is formulated in partnership with patient, family and / or carers. This is reviewed each intervention and amended to reflect changes in need.

If it is identified that a patient requires admission to a facility but does not require acute care then RRRT will contact the social worker to arrange respite. If the patient is active on the RRRT caseload this is undertaken by the team Social Worker, if the patient is a new referral but the assessment undertaken indicates the need for respite this is usually undertaken by the social workers within HCS therefore we would refer on to this service.

If the patient deteriorates during any contact with the service the RRRT undertake a comprehensive clinical assessment utilising the appropriate tools to guide diagnosis and a management plan. Further investigations may be undertaken i.e. venepuncture, point of care testing and cannulation. Following assessment RRRT

follow the policy and escalation process within the NEWS and deteriorating patient policy (both of these are currently in the process of being reviewed and updated to reflect national changes). Safety of the patient is paramount and if indicated an emergency ambulance is called which may determine a lesser assessment is undertaken due to the severity of the clinical deterioration and the need for urgent admission to JGH.
Patients are offered the following patient information leaflets:-

- 'How we use your records' ensure patient or their representative has the opt out of electronic record share letter
- Rapid Response admission leaflet
- Service specific i.e. cannula management

All patients should be offered the opportunity to complete the patient satisfaction survey on discharge

Care and support

All nursing care needs are met and delivered by competent nurses and non-registrant staff returning people to independence and assist in the recovery from acute / crisis episodes. Partnership working to develop care plans is promoted and actively encouraged. Consent for all interventions is required. Adult and children are safeguarded by trained staff who follow safeguarding partnership board Intercollegiate document HCS adults and children's safeguarding adults – follow safeguarding utilising policy and procedures within policies and procedure.
Adult and children are safeguarded by staff who follow working together to safeguard children 2019 and adult (2018) and children (2019) roles and competencies for healthcare staff RCN intercollegiate documents, along with adhering to relevant safeguarding policy and procedures. FNHC are actively involved in Jersey safeguarding partnership board *https://safeguarding.je/* and both adult and children in addition to the policy and performance sub groups.
Links: Working_Together_to_Safeguard-Children.pdf

Communication and involvement

RRRT have and maintain a user-friendly information leaflets which outline the service available. This will be made available to the public on request, and will also be available in a wide range of agreed locations across Jersey, including every GP surgery and in every relevant health or social care location.

The Service Provider will provide written and verbal information to each patient at the initial assessment visit and at any time during the time the patient is receiving care from the team if appropriate. All patients will be asked to provide feedback on admission and transfer of care from the service.

The referrer will be advised when a person has been accepted onto the caseload of the RRRT, and RRRT will communicate with the referrer and other care

professionals where issues arise that are relevant to the person's care. In that instance, communication will be on-going, with information regarding the patient's condition being updated to the patients GP at regular intervals.

Patients, carers and families are involved in the decisions around care and RRRT promote negotiated care planning. Consent is obtained prior to all admissions onto the RRRT caseload. Due to the age groups often on the caseload, negotiation of care delivery is often necessary to ensure patients receive the required care.

FNHC Website provides information about the services we offer *www.fnhc.org.je*
Written information about the service is provided and discussed with patients and their families as appropriate and verbal information at assessment.
FNHC staff have access to the services of the Big word telephone interpreting service and written translation services ' Face to face translation services including Makaton and BSL can be accessed via HCS interpreting services.
Relevant leaflets including pressure ulcer prevention are available in different languages and include pictorial information that can be discussed with a patient who is unable to read.

The service works with other professionals, patients, their family and carers as appropriate, delivering a Multidisciplinary team (MDT) approach to support and coordinate care.
Care plans are developed with patients and information is given about risks and responsibilities to support efficacy of nursing care and patients to make informed decisions about their care needs.

Consideration is given to the patient's capacity to make decisions. Where capacity to make a decision is in question a grade 5/6 will undertake a risk assessment and liaise with the GP to jointly undertake a formal capacity assessment that is then documented on hard copy The DN teams empower people to make decisions for themselves wherever possible, and protects people who lack capacity by ensuring they are at the heart of decision making about their lives. The Capacity and Self-Determination (Jersey) Law 2016 which came into force on 1st October 2018 maximises people's participation in any decisions made on their behalf, with such decisions made in their best interests.
https://www.jerseylaw.je/laws/enacted/Pages/L-30-2016.aspx
https:/safeguarding.je/we-content/upload/2016/12/2016-09-29-Final-Reviewed-Capacity-Policy-SAPB.pd

Rights and responsibilities

Staff are protected with employment terms and conditions, duty of care terms and conditions, employment law, safer recruitment, awareness of human rights, Professional bodies – NMC / RCN health and safety at work, codes of conducts

FNHC has a duty of care to protect the safety and wellbeing of both patients and staff. This is supported by a robust clinical and corporate governance, risk and quality assurance system.
As part of this system FNHC has a range of polices including;

- Confidentially policy

- Data protection policy
- GDPR
- Health and safety policy
- Subject access policy
- Complaints policy
- Whistle blowing policy
- Clinical policies and procedures
- HR employment policies

The nursing team delivers care that is informed by;

- A person's right to be safeguarded
- Human rights legislation
- Capacity and self-determination legislation
- Equality and diversity policy
- NMC code of conduct
- Health care support workers code of conduct
- 6 C's
- Best practice guidance in the absence of relevant legislation
- A range of clinical policies
- FNHC strategic delivery plan

Staff rights and responsibilities are protected by

- Employment terms and conditions
- Employment law
- Staff Handbook
- Allegations against staff policy
- Whistle blowing policy
- Health and safety policy
- NMC code of conduct
- Code of conduct for healthcare support workers
- Grievance policy
- Equality and diversity policy
- A range of clinical policies
- Union recognition
- Professional registration

8. Staffing arrangements

Numbers and qualifications of staff	All registered nursing staff within FNHC are registered with the NMC and are required to re-register annually and revalidate 3 yearly and this is monitored by HR. This also includes additional parts of the register for specialist qualifications such as public health nursing. All staff regardless of seniority or role and as part of our safer recruitment process have their qualifications verified (including professional registration and DBS check as required).

	Gaps in employment are also scrutinised when full employment history is not available and further informant sought as required. References and health checks are also conducted prior to appointment to ensure fitness to practice. Staff can also be observed in practice as part of the recruitment process. Where higher level of experience or specialist knowledge is required, qualifications and knowledge will be identified within the personal specification, and within the interview based competency questions as part of the recruitment process. Every member of staff also has an annual personal development plan and mid-year review. This is also a way of identifying professional training. Each staff member has their own training record (recorded by the education and training department) that records and monitors mandatory and professional training undertaken each year. Staff also receive regular management, clinical and safeguarding supervision that can also be used. **RRRT have 23 WTE staff from various disciplines.** Manager's name and qualifications Clare Stewart RGN, Diphe, BSc (hons) V300 PG Cert Long Term Conditions, MSc Advanced Clinical Practice Senior staff 6.5 Senior RGNs 3 of whom on MSc Pathway 2 Senior RMNs – Both on Degree pathway 1 Assistant Practitioner – Foundation Degree, Final stages of QCF L3 2 SHCA – Both have QCF L3 4 HCA – All have QCF L2 and working towards L3 1 Reablement assistant QCF L3 1 Reablement support worker QCF L3 1 Qualified Senior Occupational Therapist – registered with professional body 1 part time Qualified Senior Physiotherapist – registered with professional body 1 Qualified Social Worker – Registered with professional body
Staff levels	Qualified Therapist staff and social workers work core hours Mon-Friday The nursing team and support staff work on a 7 day rota from 07.30-20.30hrs RRRT caseload is unpredictable (attached rota) but we have a minimum number rostered on each day which would be: 2 trained nurses for co-ordinating and caseload

	1 trained nurse based in JGH for In reach role 2 support workers 1 therapist This would be minimum acceptable staff but is not replicated daily.
Specialist staff	*NA*
Staff deployment	*NA*
Delegated tasks	Accountability for delegation of nursing tasks remains with the registrant. Delegation of care to unregistered care staff is informed and overseen by the DN standard operating procedures patient pathway (2018) and Personal care and clinical tasks policy (2017). Patients where clinical task have been delegated remain on the caseload and the appropriateness of the care plan and delegation of care is reviewed regularly by the registered nurse, informed by the patients care needs. The service also has a competency framework for clinical task relevant to each grade. Both registrants and non-registrants receive training in all aspects of clinical care appropriate to their role and level of responsibility.
Other staff	Administration staff from the admin hub support the DN team Monday to Friday. Governance team including Clinical effectiveness lead Education and development lead Practice development lead Safeguarding lead Corporate and finance team
Staff training	All FNHC staff and committee receive corporate and local induction appropriate to there are of work and as identified by the manger and individual staff member. Induction includes completion of mandatory training, shadowing staff, competency assessment, and introduction to key staff in the organisation including the CEO. The induction covers EMIS our electronic patient record system and ASSURE our electronic risk management and incident reporting. FNHC has an annual education and training prospectus detailing mandatory training for both registrants and non-registrants including safeguarding adults and children (please see below).  Prospectus revised May June 2019.pdf

	Service specific training which includes but is not limited to ANTT in full, wound management, continence management with associated competency framework also can be provided.
9. Services and facilities	
Provision of food / drinks / snacks	Food hygiene training is mandatory for those involved
Activities	*NA*
Specialist equipment	Staff have clinical monitoring equipment appropriate to nursing assessment needs. Staff use clinical consumables to deliver nursing care. Annual inspections and calibration service process in place for clinical equipment. Safety alerts relevant to equipment used are disseminated and actioned as appropriate. Additional or more specialist equipment not commissioned by the States of Jersey is sometime provided through fundraising and our charity work. It is however still managed with the same robustness, systems and processes Clinical and monitoring nursing equipment appropriate to nursing assessment MDA Safety alerts Annual equipment calibration
Communal areas *(Care homes/Day Care)*	NA
Dining areas *(Care homes/Day Care)*	NA
Access to outside space *(Care homes/Day Care)*	NA
Specialist bathing facilities *(Care homes/Day Care)*	NA
Number single occupancy bedrooms *(Care homes)*	NA
Number of shared rooms *(Care homes)*	NA
Number of rooms with en suite facilities	NA

Security arrangements *(Care homes/Day Care)*	NA
Office/meeting rooms *(Home Care, Care homes/Day Care)*	There is locked archive records storage at le Bas. Le Bas reception is staffed during office hours and electronic ID cards access to building is used to restrict access at all times. Signing in book for visitors, that protects the person's identity and respects confidentiality If service users/professionals enter the building they are accompanied to the meeting room by the FNHC member of staff and then accompanied back out to reception to sign out on completion of the meeting. Staff meetings held in private space or individual offices and there are meeting rooms at Le Bas and G le G according to requirements. Consideration is always given to confidentiality and risk. FNHC have dedicated training rooms and equipment at G le G
10. Quality Assurance and Governance	
Complaints and concerns	Patients and people who use our services are able to make verbal complaints in person and by telephone and also written complaints by email, letter and through FHNC enquiry email enquiries@fnhc.org.je which is found on FNHC website and leaflets. Patients of staff can also contact any manger, CEO and any member of the FNHC committee. Anyone wishing to make a complaint can be supported through the process. FNHC has a complaints policy which details management of complaints and timeframes. Compliments and complaints are reported on by each service along with other performance, quality indicators and outcomes measures which is reviewed and monitored by commissioners at their external quality boards, the committee at the committee meetings and governance subgroup. The senior management team attend a monthly Quality Assurance, Governance & Performance meeting which ensures that FNHC continuously improves driving a culture of learning across the service and organisation . .

Organisational structure	https://www.fnhc.org.je/media/43133/strategy-2019-to-2023.pdf  RRRT Org Chart.pdf page 5-6
Service oversight	Service oversight is provided both internally and externally to FNHC. Internally, the service is monitored at the quarterly clinical governance and quality assurance group and the performance board led by the Governance and Quality Lead and CEO. The service and organisation is also quality assured, and risk managed by the committee to ensure appropriate clinical and corporate governance is in place. Reports are received by the committee at each meeting and though the finance and governance sub groups. Each service maintains a risk registers which is managed by the operational lead and monitored by senior management team. High scoring risk are managed and mitigated through the corporate risk log reported to the committee. A quarterly performance dashboard is developed for each service including incidents, broken down by type and severity pressure ulcers, complaints and mandatory training. These all form part of the governance and quality assurance. FNHC committee also has oversight of service quality and performance data. Both adult and children safeguarding action plans are monitored at FNHC's internal safeguarding meeting, and through membership of the external safeguarding partnership board and completion of annual Safeguarding Partnership Board Memorandum of Understanding audit. FNHC also has an annual audit programme which includes but is not limited to record keeping, infection prevention and control and adrenaline. Externally FNHC reports to the commissioners who performance manage and quality assure the service on a quarterly basis at their Quality Board FNHC as a charity also holds a public Annual General Meeting (AGM) where it publishes all of the financial accounts, which are also externally audited, the chairs and CEO's reports. FNHC's new 5 year strategy (2019-223) and annual service plans also provide the organisation with oversight and accountability. https://www.fnhc.org.je/media/43133/strategy-2019-to-2023.pdf

Involvement	Patients are offered the opportunity to complete the patient satisfaction survey based on NHS England friends and family test https://www.nhs.uk/using-the-nhs/about-the-nhs/friends-and-family-test-fft/ FNHC Committee members are drawn from the public and from a range of professional backgrounds and life experiences which includes those who have used our service and may use our service in the future. FNHC also holds an AGM where financial accounts and CEO reports are presented and these are also accessible on our website. Learning from incidents, SCR's and complaints raised by those who use our services also inform service delivery and redesign. Service user's engagement and feedback at any events or at any contact with our organisation is encouraged. Staff also are invited to complete a staff engagement survey at least every 2 years, and the findings are developed into an action plan. The implementation of the plan is overseen by the staff wellbeing group.