Jersey Care Commission

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	FNHC Out of Hospital Services
Address of Provider	Le Bas Centre St Saviours Road St Helier
Legal status of service	Charity

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)	☒

Mental Health	☐	Nursing care – includes all the categories above excluding children	

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	

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 a new approach to the delivery of community based services and the development of the service will need to take into account the wider developments of the Jersey care Model objectives particularly the intermediate care strategy. The service will be adaptable and flexible to meet the needs of a health service undergoing significant redesign and will provide a 24-hour nursing service led by Advanced Clinical Practitioners. With this in mind, 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 to manage crisis situations

Care will be person centered and will include mental as well as physical health needs, delivered by a range of professionals through an Integrated Multi-Disciplinary Team (MDT) and the focus will be on achieving agreed outcomes for both individuals and for the system as a whole. It will foster 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 will provide 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 will often be 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 will be by titrating the patients' needs based on clinical risk management using the RAG acuity tool and available resources.

The integrated service will have the ability to:-

- Receive referrals from other health care professionals working in the community who need urgent 24 hour 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 will consist 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 including trainee advanced clinical practitioners
- Provide rapid assessment to determine the care a person needs during a period of ill health or instability
- The team will provide 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 will 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 will be utilised to support RRRT within the community through Integrated Care Pathways.

- The team will have the skills to provide a consistent, responsive homecare reablement service which supports people to maximise their independence, health and well being
- The team will 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 will be available to deliver 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. It is anticipated that overnight there will not be an ongoing caseload and the majority will be seen and discharged back to core day services. Occasionally there will be a small number of patients requiring ongoing care for a time-limited period for e.g. end of life symptom management.
- The team will assess RRRT patients on an individual basis
- The team will 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 will 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 will have the right equipment to support diagnosis in the community
- The team will utilise and explore further possibilities for the use of assistive technologies to support people at home
- For those people needing ongoing support, the team will 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 will be available 24 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 72hrs 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. This will be dependent on the patient need at time of initial assessment and may only require one visit. Overnight service may have reduced length of stay, as predominantly referrals could be handed over to core day services once initial crisis managed overnight. The support provided will take into account the persons social circumstances and available network of support in their home environment. If the person’s needs cannot be safely managed or stabilized, the person will be 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 will be available to all eligible adults irrespective of race, gender, disability or sexual orientation. Mental health provision is for over 65 year olds.

Access for people with sensory impairment and/or physical disability

The team will visit 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 will ensure 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

Referrals are accepted by telephone between 07:30 hrs to 20.000 hrs, for day service, Overnight referrals will be from 20.00 – 07.30 am 7days 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 clinician 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) 2hour response
Crisis (Level 2) 2 hour response
Reablement (level3) 24 hour response
Mental health 2-24 hour reponse.
Overnight service 2 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
Definition:
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
Aim of crisis response
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
Aim of Reablement
Helping people recover skills and confidence to live at home, maximising 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

Limitations

Patient is suitable for referral if the answer is yes to the following:	
• Aged 18 years or over except mental health then must be over 65	Yes ☐
• Patient has designated medical responsibility	Yes ☐
• Patient gives consent to service	Yes ☐
• Patient requires management within target length of stay	Yes ☐
• Social circumstances appropriate and accessible	Yes ☐
• For hospital patients medical team have documented in medical notes suitable for RRT	Yes ☐
• It is safe to transfer / keep care in community and RRRT have appropriate resource to do so	Yes ☐
• Patient is to be admitted into hospital if not accepted	Yes ☐
• Hospital patient has had senior doctor review	Yes ☐
• If cardiac failure, the referrer must have discussed with cardiology	Yes ☐
• Has reablement goals and to be consistently engaging in rehab sessions on the ward	Yes ☐

Reason why patient is not suitable for RRT referral		
• Patient has life threatening illness	Yes ☐	No ☐
• Confusion with concerns for safety particularly overnight	Yes ☐	No ☐
• Chest pain of ischaemic nature	Yes ☐	No ☐
• Acute head injury	Yes ☐	No ☐
• Need for urgent orthopaedic or surgical assessment or review	Yes ☐	No ☐
• Doctor, patient or carer unwilling to participate	Yes ☐	No ☐
• Social circumstances not appropriate	Yes ☐	No ☐
• Any situation resulting in unacceptable risk	Yes ☐	No ☐
• RRT over capacity	Yes ☐	No ☐
• Social care package or plug gaps from other services	Yes ☐	No ☐

7. How the service is provided

Commencing care/admissions, assessment, planning and review

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.

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 we have received a referral and review the client, patient consent must have been gained prior to referral. The assessment can be within JGH or the patient's home. The Clinician in charge of the shift is responsible for triaging all referrals and scheduling the appropriately skilled staff member to visit the patient. Overnight the ACP will triage and review patients liaising with JDOC and HCS24 as required.

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 NEWS2 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 clinician in charge, documented on EMIS, the white board and discussed at handover with a clear plan put in place for its completion. Overnight to ensure hand over to relevant service.

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 need; progress of patients on the caseload and allocated each day following handover with the allocated clinician in charge.

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. Overnight service will discharge onto appropriate core day services if appropriate.

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 Sepsis and recognition of

deteriorating patient policy. 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.

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. Other communication used if required are the Interpreter, Big Word, different language leaflets, admission leaflets and translator services.	
Rights and responsibilities Patients have the right to complain, refuse treatment, refuse access, refuse care, and to be safeguarded. RRRT will ensure these rights are protected by utilising the appropriate policies and working within the mental capacity and self-determination legislation, will use best practice guidance regarding consent and adhere to the principles of GDPR Staff will be 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	
8. Staffing arrangements	
Numbers and qualifications of staff	*RRRT have 24 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 Other senior staff 3 Trainee Advanced Clinical Practitioers all on the MSc pathway 8.5 Senior RGNs 3 of whom on MSc Pathway 1 Senior RMNs – On MSc pathway 2 SHCA – Both have QCF L3 5 HCA – All have QCF L2 and working towards 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 part time qualified Physiotherapist – registered with professional body 1 part time Qualified Social Worker – Registered with professional body
Staff levels	Qualified Therapist staff and social workers work core hours Mon-Friday The nursing team work on a 7 day rota 24 hours per day

	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 overnight 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	NMC delegation and accountability Competency based framework and service specific training Regular review of competence and delegated tasks and appropriateness of delegated tasks
Other staff	Admin Hub, governance, corporate
Staff training	Induction policy, bespoke induction plan for each new member of staff, training prospectus detailing statutory and mandatory training including safeguarding. Service specific training with competency framework
9. Services and facilities	
Provision of food / drinks / snacks	Food hygiene training mandatory for those involved
Activities	*NA*
Specialist equipment	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)*	Locked archive storage Manned reception with restricted access Electronic access through personal ID at all times Signing in book for visitors Service users are accompanied into building and taken to appropriate meeting room Staff meetings are held in private space according to requirements
10. Quality Assurance and Governance	
Complaints and concerns	FNHC have a Complaints policy and quality and governance Manager / Lead. All complaints and concerns are escalated to the appropriate manager as per policy and dealt with in line with policies and procedure.
Organisational structure	*Corporate Org Structure 2.2.pdf*
Service oversight	Quarterly internal and external quality boards Quarterly Committee governance Risk register Mandatory training matrix Quarterly Performance data Internal safeguarding meeting Membership of SBP Annual Audit programme
Involvement	Survey monkey – client satisfaction Committee members engagement Learning from complaints, SCRs and SUIs AGM