Forever Care Ltd

# Fairlight Nursing Home

## Inspection report

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## Ratings

| Overall rating for this service | Inspected but not rated |
|---|---|

| | |
|---|---|
| Is the service safe? | **Inspected but not rated** |
| Is the service well-led? | **Inspected but not rated** |

# Summary of findings

## Overall summary

About the service
Fairlight Nursing Home is situated in Rustington, West Sussex. It is a residential 'care home' providing care for up to 62 people who may be living with dementia, physical disabilities, older age or frailty and who require nursing care. At the time of inspection there were 60 people living at the service.

People's experience of using this service and what we found

Lessons had not always been learned and people had not always received safe care and treatment when they had experienced falls and head injuries. Staff did not always ensure they followed current infection prevention and control guidance (IPC) when supporting people. Some systems relied upon to provide oversight of all people's clinical needs were not always effective. The registered manager and provider had not identified the concerns found as part of this inspection in relation to falls management and IPC.

When our concerns were fed back to the registered manager they took immediate action to ensure people received safe care and treatment and systems were implemented to mitigate further risk.

Staffing levels had improved since the last inspection yet required further improvement. We have made a recommendation that consideration is made to the deployment of staff and allocation of additional responsibilities during the COVID-19 pandemic. This will help the provider ensure staff are able to meet people's needs and there is sufficient and effective oversight of people's care.

People and staff told us staff worked as a team to help ensure people's needs were met. The registered manager had been creative when deploying staff to help ensure staffing levels were used to their best effect.

People's care had improved in relation to the concerns found as part of the last inspection. This included enhanced oversight of medicines and modified diets.

People told us they were happy and felt safe at the service. They told us they felt well-cared for by staff. One person told us, "I feel safe, we are well looked after. The staff are all kind".

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection (and update)
The last rating for this service was Requires Improvement (Report published 17 January 2020). The registered manager and provider completed an action plan after the last inspection to show what they would do and by when to improve.

Since the last inspection, there had been improved oversight of people's care in relation to the concerns we had previously found. At this inspection, we found new concerns in relation to some people's safe care and

treatment. Concerns remained about the oversight of aspects of some people's care. The registered manager and provider were still in breach of regulations.

Why we inspected

This inspection was prompted in part due to concerns received about two specific incidents relating to medicines management and falls. Following one of these incidents, a person using the service died. These incidents are subject to ongoing investigation. As a result, this inspection did not examine the circumstances of the incidents. However, we looked at how the registered manager and provider had learned lessons from the incidents to help ensure people's safety.

We undertook this targeted inspection to see if the concerns we found at the previous inspection had improved. We checked whether the Requirement Actions we previously served in relation to Regulations 12, (Safe care and treatment), 17 (Good governance) and 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met. We also checked to see that the previous breach of Regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009 had been met. We looked at the care people had received in response to concerns that had been raised to us since the last inspection. The overall rating for the service has not changed following this targeted inspection and remains Requires Improvement.

CQC have introduced targeted inspections to follow up on enforcement action or to check specific concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

At this inspection, we have identified continued breaches in relation to safe care and treatment and the leadership and management of the service. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will continue to monitor information we receive about the service and we will request an action plan from the registered manager and provider to understand what they will do to improve the standards of quality and safety. We will work alongside them and the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Inspected but not rated**

At our last inspection we rated this key question Requires Improvement. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

### Is the service well-led?

**Inspected but not rated**

At our last inspection we rated this key question Requires Improvement. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

# Fairlight Nursing Home

**Detailed findings**

## Background to this inspection

The inspection
This was a targeted inspection to check whether the registered manager and provider had met the requirement actions that were served at the last inspection in relation to Regulations 12 (Safe care and treatment), 17 (Good governance) and 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also checked to see that the previous breach of Regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009 had been met. As part of this inspection, we looked at the care people had received in response to concerns that had been raised to us since the last inspection.

We also looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was undertaken by two inspectors and an assistant inspector.

Service and service type
Fairlight Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.
The home had a manager who was registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the home is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and health care professionals who have worked with the service. We used the

information the registered manager sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We observed the care and support people received. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke to three people about their experiences of the care provided. We also spoke to six staff and the registered manager. We reviewed aspects of care nine people had received which included care plans, risk assessments and medicine administration records. We looked at staff training and competence and a variety of records relating to the management of the service, which included policies and procedures and quality assurance processes.

After the inspection
We continued to seek clarification from the registered manager to validate evidence found. We sought assurances from the registered manager about falls management and the infection, prevention and control processes within the service. We communicated with three external social care professionals.

Inspected but not rated

# Is the service safe?

## Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Requires Improvement. At this inspection, the rating of this key question has not been changed, as we have only looked at part of the key question we had specific concerns about. The purpose of this inspection was to explore the specific concerns we had about Fairlight Nursing Home. We will assess all the key questions at the next comprehensive inspection of the service.

Medicines management; Assessing risk, safety monitoring and management

At the last inspection, the registered manager and provider were in breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There were concerns in relation to medicines management. People living with Parkinson's' disease had not always been supported to have their medicines at the prescribed times. Staff had not always ensured there was enough time in-between doses of prescribed pain medicines and this increased the risk of people receiving too much medicine. There was a lack of oversight and assurances when people required a texture-modified diet to minimise their risk of aspiration and choking. At this inspection, improvements had been made and people had received safe support in these areas. We found new concerns in relation to infection prevention and control (IPC) and falls management. There was a continued breach of Regulation 12.

- Falls management was not always safe. Two people, one of whom had a history of falls, had experienced falls which involved them hitting and injuring their heads. Staff had not always ensured they sufficiently monitored both people to help identify any changes or deterioration in their health. Urgent medical advice from external healthcare professionals had not always been sought to help ensure people received timely, safe care and treatment following their fall. This meant people had not always been protected from the risk of avoidable harm.
- People had not always received consistent support from staff if they had experienced a fall or head injury. When people had fallen and hit or injured their heads, staff had completed observations to monitor for any changes or deterioration in their condition. The frequency and duration of the observations were inconsistent and staff demonstrated a mixed understanding as to how often and for how long they needed to observe people. This increased the risk that people would not be sufficiently monitored to identify any changes or deterioration in their condition.
- One person who was prescribed medicine that could increase their risk of bleeding should they fall, had fallen and hit their head. Consideration of the medicine the person was prescribed had not been made. Staff conducted observations to monitor for changes in the person's condition but this was only conducted for an hour following their fall. In the days following their fall, their condition deteriorated further and staff had contacted the person's GP as they displayed symptoms of a head injury.

When this was fed back to the registered manager, they took immediate action to minimise risk. They revised their policies and provided staff with clear guidance to help ensure all staff provided consistent and safe care when people fell.

Preventing and controlling infection

● As part of CQC's response to the coronavirus pandemic we are conducting thematic reviews of infection control and prevention measures in care homes. We were not always assured all staff were following safe infection prevention and control measures or Public Health England (PHE) guidance in respect of COVID-19. Some staff were wearing appropriate personal protective equipment (PPE) when providing support to people, but this was not always consistent. Some staff were assisting people to eat their meals and were not wearing single-use gloves to protect people and themselves from the risk of potential infection. This was not in accordance with PHE guidance when providing direct contact support to people.

● Staff wore fluid repellent face masks to minimise the risk of potential infection to people as well as themselves yet did not always use these in a safe way. Two members of staff were observed with their face masks underneath their chins whilst having drinks and snacks. This increased the risk that staff and people were exposed to potential infection.

● People were not always encouraged or supported to socially distance from each other to minimise the risk of transmission. People, some of whom were living with dementia and relied on staff to assist them with their daily support needs, were not always supported to maintain a safe distance from one another. For example, people were sitting near each other when eating their meals at dining tables or alongside each other in armchairs or wheelchairs when in the communal lounge. This increased the risk of the transmission of potential infection.

When this was fed back to the registered manager, they took immediate action. They ensured all staff were provided with current PHE guidance and they were all wearing appropriate PPE when providing direct contact and support to people. Additional tables and chairs were provided and better use was made of communal areas to ensure people had the space to distance from each other.

Although some risks in relation to people's care had been minimised, not all care and treatment was provided in a safe and consistent way for all people. The registered manager and provider had not considered or assessed all risks to people's safety to ensure staff were doing all that was reasonably practicable to minimise risk. This included preventing and controlling the spread of infection and providing safe care and treatment when people fell. This was a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager had accessed support from the local authority and clinical commissioning group in relation to IPC. Staff had undertaken IPC training and ensured they washed or sanitised their hands in-between providing support to different people.

● The registered manager and provider had implemented screening processes to minimise the risk and transmission of infection. This included regular COVID-19 testing for staff and people. Hand washing facilities and thermal imaging cameras to take visitor's and staff's temperatures had been installed in the entrances to the service to help minimise the risk of infection. People told us they felt safe by the measures in place. One person told us, "They wear the mask all the time, even the night staff".

● People had been supported to stay in contact with their loved ones via telephone or video calls. Staff had laminated a note one person had received so this could be sanitised before being given to them, therefore minimising the risk of cross-contamination. Visitor pods with clear Perspex screens had been built and installed so people could see and enjoy visits from their relatives whilst ensuring all people's safety. People told us they felt safe with the measures staff were taking when supporting them. One person told us, "They keep the place clean, I have my room cleaned regularly, more so now due to Covid".

Staffing; Learning lessons when things go wrong

At the last inspection, the provider was in breach of Regulation 18 (Staffing) of the Health and Social Care Act

2008 (Regulated Activities) Regulations 2014. This was because people and staff consistently told us staffing levels set by the provider were not always sufficient and they impacted on staff's abilities to support people in a timely, calm and effective way. At this inspection, some improvements had been made and the provider was no longer in breach of the Regulation. Further improvements were needed to ensure staff numbers and their deployment, including those responsible for having oversight of people's care, reflected the additional duties staff were required to undertake due to the COVID-19 pandemic.

● Due to the COVID-19 pandemic, staff had been required to take on additional roles and responsibilities to implement new protocols to help minimise the risk of infection. This included supporting people and staff to undertake regular COVID-19 tests and facilitating contact with people's loved ones when there were restrictions on visits. People who required assistance with eating and drinking had sometimes been supported by their loved ones who had visited at meal times to offer support before the pandemic. Due to the restrictions on the amount of people entering the home, this had stopped and staff told us this had an impact on their abilities to meet all people's needs in a timely way. Staff told us they worked hard to ensure people's needs continued to be met despite the additional work they undertook. There was a lack of consideration of the additional duties staff were required to undertake and the impact this had on their abilities to meet all people's needs.
● Staff's roles and responsibilities as well as their deployment, had been adjusted during the pandemic. Staff who had previously been allocated supernumerary time to enable them to have oversight of people's care, had this reduced. This had impacted on their oversight of people's clinical needs to ensure they had received safe and effective care following falls. For example, accidents and incidents had not always been reviewed by clinical staff to ensure people received appropriate and timely support following falls. As this had not happened, learning had not been implemented to improve safety for people should they fall and hit or injure their heads.
● Some staff told us that due to some external health professionals not visiting the home due to the pandemic, this placed additional demands on their time as they had to facilitate skype appointments or send documentation electronically. People's needs were assessed before moving into the home. Due to the pandemic, the assessment process had changed. Staff told us they relied on assessments being undertaken by external professionals and there were times when there was a breakdown in communication about people's needs. This had an impact on staff's time as they told us they were often not fully aware of people's needs. This meant they could not always effectively balance the needs of people with others already in the home. Although the registered manager used a tool to help align staffing to people's assessed needs, the lack of clear and accurate information about new people's needs meant this was not always effective.
● Some staff told us there were not enough staff. One member of staff told us, "There's not really enough staff. I just feel that we could have one or two extra staff for people's safety because we can't be in two places at once. We have three staff upstairs, if two are helping a person that needs two members of staff and the third is supporting another person, there is no one else to keep an eye out on everyone else". Another member of staff told us, "We do have several clients that require two staff. It depends, some days there are enough, some days there are not. Sometimes with the bells going off you're running from A to B. It can be difficult because we may be helping someone that has two staff and then the bells start ringing but we can't stop what we're doing to check it".
● There was mixed feedback from staff. Some staff told us they felt listened to and that when they had raised their concerns improvements had been made. One member of staff told us, "The carers kept telling us nurses they needed more staff and we told the manager, she listened". Another member of staff told us, "I don't think we get as much time as we could. We talk to people during personal care, introduce ourselves and join in conversation with them. We don't get the time to spend with them like we used to with activities".

We recommend the provider considers the overall flexible deployment of staff during a time of crisis.

● People told us and our observations showed, staff were attentive and worked hard as a team to ensure people's daily needs were met. This helped ensure people were not adversely affected by the additional tasks staff were required to complete due to the pandemic. One member of staff told us, "We have got a really good team at the moment. We got closer during the first Covid lockdown and isolation. We knew we could rely on each other. We still help each other, if we're finished in our section we go to help in other sections". People were complimentary about the support they received from staff and told us they felt well-cared for. One person told us, "I feel safe, we are well looked after. The staff are all kind".
● The registered manager had been creative with the deployment of staff and had also introduced dedicated roles for staff to relieve pressure on nursing staff so they would have more time to meet people's nursing needs. For example, care managers had been employed who were responsible for devising and reviewing people's care plans to ensure they were current. This meant nursing staff had more time to provide direct care to people. One member of staff told us, "I do get time to spend with people now. Because we have a care manager both sides, doing the care plans, it relieves pressure on me sitting at the computer and gives me more time to spend with people. Now I just check what is in there and if needed it's just a little update. I feel like a lot of time has been taken off me, I feel more happier it's documented and I get quality time with residents".

Inspected but not rated

# Is the service well-led?

## Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Requires Improvement. At this inspection, the rating of this key question has not been changed, as we have only looked at part of the key question we had specific concerns about. The purpose of this inspection was to explore the specific concerns we had about Fairlight Nursing Home. We will assess all the key questions at the next comprehensive inspection of the service.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people.

At the last inspection, the registered manager and provider were in continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There were concerns with regards to the oversight of people's care. Quality assurance processes had not always identified the shortfalls that were found as part of the inspection. At this inspection, some improvements had been made and there was increased oversight of people's care. Systems had been introduced to ensure staff had clear information and guidance on people's needs relating to medicines management and modified diets. At this inspection, we found new concerns with regards to the oversight of falls management and Infection Prevention and Control (IPC). The registered manager and provider were in continued breach of Regulation 17.

● Following the last inspection, the registered manager and provider sent us an action plan to tell us what they would do to improve their oversight in relation to the concerns that had been found. At this inspection, we found they had met their action plan but had failed to ensure sufficient oversight of all aspects of people's care. Systems relied upon to identify shortfalls had not always been effective. The registered manager and provider were first made aware of the concerns found at the inspection through our feedback and had not identified these themselves.
● Some staff held champion roles and had dedicated responsibilities to help promote safe and appropriate practice. Infection prevention and control audits had been conducted yet had not identified that some staff were not following current Public Health England (PHE) or IPC good practice. This raised concerns about their effectiveness. For example, some staff were not advised to wear single-use gloves when providing direct support to people. Social distancing was not always promoted. These practices increased the risk of potential infection spreading.
● The provider did not have sufficient oversight of the care people received. The provider did not conduct audits of the service and instead relied on those conducted by the registered manager and other allocated staff to highlight areas of practice that required improvement. Although the registered manager had significantly improved most aspects of people's care, it had not been identified that some people had not received safe care and treatment when they fell.
● Due to the COVID-19 pandemic and its implication on staffing, staff who were usually responsible for the

oversight of people's clinical needs had been required to provide direct nursing care to people. This had impacted on the effectiveness, oversight and quality of some people's care. As neither the registered manager or provider had ensured effective clinical oversight of staff's decisions, it had not been identified that people had not always been provided with safe or timely care when they fell.

● When incidents had occurred, there was a lack of clinical oversight to ensure staff had acted appropriately and people had received safe care. Previous incidents had not always been used as opportunities to learn. For example, in July 2020, one person had experienced a fall and a head injury. Following the incident lessons had not been learned and it had not been identified that the provider's policy which provided guidance to staff about the actions they should take, did not provide sufficient, consistent or clear advice for staff to follow. Therefore, when we inspected four months after the incident, we found similar concerns about the lack of oversight of people's care when they experienced a fall and head injury. When we raised our concerns to the registered manager they took immediate action. They reviewed and revised the provider's policies to ensure staff were provided with clear guidance to mitigate further risk.

● Some incidents which related to poor medicines or falls management had occurred when agency staff were working. The registered manager and other senior staff had provided feedback to the agency about staff's practice. However, had not considered other measures that could be implemented at the service to help assure themselves agency staff held the appropriate skills and competence to safety and effectively carry out the tasks they were allocated.

● Records did not always document the care people had received. Following the inspection concerns were raised to the registered manager and it was identified that some staff were not always accurately recording bruises that people had sustained. Staff were completing body map charts indicating where the bruising had been found, but had not always documented this on the electronic care planning systems to help ensure there was sufficient oversight and appropriate action taken when there was unexplained bruising.

Significant progress had been made by the registered manager since the last inspection to help improve aspects of people's care and provide improved oversight, yet neither they or the provider had ensured all systems and processes were always operated effectively to ensure compliance. Quality assurance processes to help assess, monitor and improve the quality and safety of the service were not always effective. This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Since the last inspection, the health and social care sector has faced unprecedented challenges caused by the COVID-19 pandemic. This had impacted on the provider's, registered manager's and staff's work whilst they responded to the daily challenges the pandemic posed. During this time, improvements had continued to be made to help implement the provider's policies and procedures to ensure most people's healthcare needs were met. For example, the registered manager had introduced clear and safe systems to manage medicines when people required pain management or timely access to prescribed medicines for those living with Parkinson's disease. Improvements in the systems and guidance provided to staff when people required a texture-modified diet had ensured people received safe care in these areas.

● People and most staff told us the service was well-led. Most staff told us the registered manager was fair and they felt well-supported and able to approach them if they had concerns. One member of staff told us, "If she is free she is always willing to listen. She supports me and fights for staff if they're in the right. But if they're in the wrong, that's when they have problems. I tell the staff that is the manager's job, we have standards to follow. The management team have a good working relationship and so if we voice our feelings, frustrations or joy, they listen".

● People and relatives had been encouraged and able to raise any questions or concerns. The registered manager operated a 'You said, We did' initiative. When queries and questions had been raised these had been responded to. For example, people and relatives had asked why visiting had been restricted during the

pandemic. The registered manager had been open and honest and advised them of the reasons why. Information and updates were sent to relatives through email or communicated during telephone conversations. The provider operated a website that was regularly updated with information to ensure people and relatives were kept informed. One person told us, "I think it runs okay here, I have no complaints. We have meetings and the manager tells us things. We are invited to talk about things, any problems or ideas".

● Despite the challenges the pandemic posed, efforts had continued to be made to ensure people received a service that met their emotional and social needs. People were observed engaging in a poetry session and were seen smiling in response. A simulated trip to the seaside had been organised and people had enjoyed watching Punch and Judy and eating fish and chips and ice-creams.

● Most records to demonstrate the care people had received had improved. Staff were accurately documenting people's care to enable the management team to oversee people's care in real-time. For example, when people had been supported to reposition if they needed assistance with moving and positioning.

At the last inspection, the registered manager and provider were in breach of Regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009. They had failed to notify us of all incidents. At this inspection, this had improved and they were no longer in breach of this regulation.

● The registered manager had notified us of incidents that had occurred to enable us to have oversight of people's care.

This section is primarily information for the provider

# Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.<br><br>The registered person had not ensured that they assessed the risks to the health and safety of service users when receiving care or treatment. They were not doing all that was reasonably practicable to mitigate any such risks.<br><br>They had not always assessed, prevented, detected or controlled the spread of infections. |

**The enforcement action we took:**

We have imposed conditions on the registered provider's registration. They are required to send us information in relation to their oversight of risks to enable us to ensure appropriate actions have been taken.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.<br><br>The registered person had not ensured that systems and processes were established and operated effectively to:<br><br>Assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services).<br><br>Assess, monitor and mitigate the risks relating to |

the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.

Maintained securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.

**The enforcement action we took:**

We have imposed conditions on the registered provider's registration. They are required to send us information in relation to their oversight of risks to enable us to ensure appropriate actions have been taken.