The Orders Of St. John Care Trust

# OSJCT Eresby Hall

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

| | |
|---|---|
| Is the service safe? | Good |
| Is the service effective? | Good |
| Is the service caring? | Good |
| Is the service responsive? | Good |
| Is the service well-led? | Good |

# Summary of findings

## Overall summary

About the service: OSJCT Eresby Hall is a residential care home. It provides personal care and support for up to 42 older people or people living with dementia. There were 38 people living in the service on the day of our inspection.

People's experience of using this service:
• People had their risk of harm assessed. Improvements had been made to safety and security since our last inspection. Staff knew how to keep people safe from the risks of harm and abuse.
• People were cared for by sufficient numbers of skilled, competent and experienced staff. Medicines were managed safely. The service was clean and homely
• People's physical, mental health and social needs were assessed and care was delivered in line with legislation and national guidance. Staff work with other professional groups to deliver effective care and support.
• People's rights were maintained and staff followed the principles of the Mental Capacity Act 2005.
• People were provided with a nutritious, varied and balanced diet.
• People were cared for by kind, caring and compassionate staff, who treated them with dignity and respect.
• People were enabled to take part in a wide range of individual and group activities.
• There was a robust process to manage complaints and lessons were learnt and improvements made when things went wrong.
• The manager was an approachable and visible leader. There was a positive culture in the service. The manager and their team were committed to improving the quality and standards of care people received. There was a good governance framework, leading to improvements in the service.

The provider met the characteristics of 'Good' in all areas. This has improved from a rating of 'Requires Improvement' at the last inspection in 2017. More information about this is in the full report.
Rating at last inspection: OSJCT Eresby hall was last inspected on 15 December 2017 (report published 30 March 2018) and was rated as requires improvement overall.

Why we inspected: We asked the provider to complete an action plan at our last inspection. We wanted to see if the provider had made progress with their action plan and that the service was safe and well-led.

Follow up:  We will continue to monitor intelligence we receive about OSJCT Eresby Hall until we return to visit as per our re-inspection programme. If any concerning information is received we may inspect sooner.

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

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

We always ask the following five questions of services.

**Is the service safe?**

Good

The service was safe

Details are in our Safe findings below.

**Is the service effective?**

Good

The service was effective

Details are in our Effective findings below.

**Is the service caring?**

Good

The service was caring

Details are in our Caring findings below.

**Is the service responsive?**

Good

The service was responsive

Details are in our Responsive findings below.

**Is the service well-led?**

Good

The service was well-led

Details are in our Well-Led findings below.

# OSJCT Eresby Hall

**Detailed findings**

## Background to this inspection

The inspection:
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The inspection was carried out by an inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this instance, in the care of older people and people living with dementia.

Service and service type:
OSJCT Eresby Hall is registered as a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
We did not give the provider notice of this inspection.

Inspection site visit activity started on 29 January 2019 and ended on 29 January 2019.

What we did:
Before the inspection we reviewed information, we had received about the service since the last inspection. This included an action plan detailing the actions the provider would take following the outcome of our last

inspection.

Due to the short notice of our inspection, we did not request the provider to complete a provider information return (PIR). This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection 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 speak with us. We spoke with the registered manager, two members of care staff, the head chef, the housekeeper and eight people who lived at the service. We also spoke with six visiting relatives, two volunteers and two visiting healthcare professionals.

We looked at a range of records related to the running of and the quality of the service. These included risk assessments, three staff recruitment and induction files, staff training information and arrangements for managing complaints. We looked at the quality assurance audits that the registered manager had completed. We also looked at care plans and daily care records for six people and medicine administration records.

Good

# Our findings

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

People were safe and protected from avoidable harm. Legal requirements were met.

Assessing risk, safety monitoring and management
• At our last inspection in December 2017 we found the provider to be in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had failed to assess risks to people's health and safety and to do all that is practical to keep people safe. At this inspection we found that the provider had made significant improvements and was no longer in breach of regulation 12.
• We found that identified safety risks to people had been appropriately addressed. For example, the gate at the top of one of the stairways was removed as it opened out over the stairs and was a potential risk to staff and people using it. People had their risk assessed to see if they could safely access the stairs. People identified at risk of falls were moved to a downstairs bedroom with their agreement..
• Systems were in place to identify and reduce the risks to people living in the service. People's care plans included detailed and informative risk assessments. These documents were individualised and provided staff with a clear description of any risks and guidance on the support people needed to manage risk. Staff understood the support people needed to promote their independence and freedom, yet minimise the risks.
• We saw up to date records were kept on the maintenance of fire safety and utility systems such as electrical items and gas appliances.
• People who lived in the service had a personal emergency evacuation plan (PEEP) in place. This provided staff with information on how to safely evacuate the person to a place of safety in an emergency.

Systems and processes to safeguard people from the risk of abuse
• People told us that they felt safe living in the service. One person said, "I feel very safe at night because the night staff check us every two hours."
• We found that recently appointed staff had received safeguarding and whistleblowing training, and guidance on how to raise safeguarding concerns and access the provider's in-house whistleblowing service.
• People were provided with a lockable space in their bedroom to keep their valuables safe. In addition, some people had the key to their bedroom door. We saw that individual risks assessments had been undertaken.

Staffing and recruitment

• At our last inspection in December 2017 we found that although there were sufficient care staff to meet people's care needs we had concerns about their capacity to respond when care and support needs increased at short notice. One this inspection we found that the registered manager had an ongoing recruitment programme to ensure that there were always sufficient numbers of available staff to meet people's changing needs.
• A robust recruitment and selection process was in place and staff had been subject to criminal record checks before starting work at the service. These checks are carried out by the Disclosure and Barring Service (DBS) and helps employers to make safer recruitment decisions and prevent unsuitable staff being employed.
• We observed that when a person used their call buzzer to request assistance that staff responded promptly.

Using medicines safely
• Robust systems were in place for the safe ordering, storage, administration and disposal of medicines. The medicine policy adhered to up to date national guidance for the safe management of medicines in care homes.
• Before care staff were signed off as competent to administer medicines unsupervised they undertook training; they observed three medicine rounds and then were assessed administering medicines on three occasions. This meant that people received their medicines safely from staff that were competent to do so.
• We observed a senior member of staff assessing another staff member's competency to safely administer medicines during the breakfast medicine round. We saw that the staff member who was administering the medicines explained what the medicines were for, offered the person a drink, remained with the person until they had safely taken their medicines and then signed the medicine administration record (MAR).
• We looked at the MAR for four people and found that medicines had been given consistently and there were no gaps in the MAR. Each record had a photograph of the person for identification purposes and any allergies and special instructions on how to administer individual medicines were recorded.
• Some people were prescribed as required medicine, such as pain relief, and staff had access to protocols to enable them to administer the medicine safely.
• When a person was unable to express vocally that they were in pain, staff had special instruction on how to observe for facial expressions and other physical signs that indicated that the person was in pain or discomfort.

Preventing and controlling infection
• We noted that all areas of the service were clean and odour free; including the up and downstairs sluices and communal toilets.
• We spoke with a housekeeper who was also responsible for laundry duties. Housekeeping staff had robust daily, weekly and deep cleaning duties to perform and cleaning tasks were signed off when completed.
• The laundry was a good example of dirty and clean flow-through system. There was ample space to minimise the risk of cross contamination.
• Risk assessments had been carried out for the safe use and storage of detergents and the provider followed the Control of Substances Hazardous to Health standards (COSHH). The COSHH cupboard was locked at all times and staff were trained on how to safely handle detergents and cleaning products.
• Staff used personal protective clothing, such as gloves and aprons when assisting people with their personal care, handling soiled laundry or disposing of clinical waste.

Learning lessons when things go wrong
• We found evidence that lessons were learnt when things went wrong.
• Incidents were recorded, fully investigated and actions were taken to resolve. When appropriate, lessons learnt were shared with all staff.

Good

# Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

People's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• Before a person moved into the service the registered manager undertook a full assessment of their physical, social, psychological, cultural and spiritual needs. Risk assessments and care plans were developed in accordance with their needs and preferences and regularly reviewed.
• When a person moved into the service for a short-term respite stay they also had their needs and preferences assessed.
• Staff kept accurate records for all aspects of people's daily care needs, such as their food and fluid intake, weight charts, blood sugar monitoring and their position changing charts

Staff support: induction, training, skills and experience
• People and their relatives told us that staff were knowledgeable, well trained and efficient. One relative said, "The staff are really on the ball."
• People were cared for by staff who were enabled to develop their knowledge, skills and experience. Staff attended mandatory training such as fire safety, food hygiene and safe moving and handling. In addition, staff were provided with training relevant to their roles and individual needs of the people in their care, such as the care of a person living with dementia.
• Newly appointed staff undertook the Care Certificate, a 12-week national programme that covered all aspects of health and social care.
• Staff spoke positively about the training they received. One senior member of care staff said, "The standard of training are high. The best I've ever had. The management encourage me to progress professionally to be a manager."
• The registered manager maintained a training matrix of all staff training. This tool alerted the registered manager when a member of staff's mandatory training was due to be updated. This ensured that people were looked after by staff who had up to date knowledge to care for them.

Supporting people to eat and drink enough to maintain a balanced diet
• People and their relatives told us that the food was good and there was always a choice. One person commented on the food since the new head chef was appointed and said, "The new chef was much

needed." There relative told us, "Definitely noticed a difference in the food."
• People were provided with a varied, nutritious and well-balanced diet. There was an option of a cooked breakfast and we saw plenty of hot and cold drinks and snacks served throughout the day. There were bowls of fruit, crisps and biscuits in all communal areas and we observed people help them self. One person said, "There is always a good food choice. So very accommodating." A relative told us, "If [name of person] wants a cooked breakfast they only have to ask, nothing is too much trouble."
• We spoke with the head chef who told us that all ingredients were fresh and sourced from a local supplier. We noted that soups, cakes and desserts were freshly made.
• Catering and care staff had access to an up to date record of individual food likes, dislikes, allergies, intolerances and special diets. All dietary needs were cross referenced with individual care plans. The head chef told us that they sat down with each person when they first moved into the service and chatted about their likes and dislikes. They said, "It's about what is individual to them." We noted that the head chef sought feedback from people once the lunchtime meal was over.
• People with swallowing difficulties had their food specially prepared. Such as mashed, pureed or liquidised. To ensure their meal was always visually appetising, individual food items were served separately on their plate.
• We observed care staff support people who required assistance to eat and drink.
• People had their risk of dehydration, malnutrition and obesity closely monitored by staff. Food and fluid charts were completed daily and weight charts were analysed for early signs of risk. The nutritional lead told us that when a person was identified at risk, that they liaised with the head chef to provide the person with a fortified diet. We saw that the head chef fortified soups, potatoes, desserts and cakes with milk, cream and butter to help people at risk maintain a healthy weight. This had a positive impact as some people had recently gained weight.

Adapting service, design, decoration to meet people's needs
• There was an ongoing refurbishment programme that addressed the needs and abilities of people who lived in the service. For example, we saw that one bathroom had been refitted with a new bath and shower.
• The service provided people with a hair salon, vintage tearoom and a pub with old fashioned pub games.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
• People and their relatives told us that care staff supported people to access healthcare professionals such as their GP, dentist or dietitian. One person said, "I was in need of antibiotics and staff got the doctor out straight away."
• We saw that when a person had swallowing difficulties that the speech and language therapist (SALT) was involved to assess the person and advise staff on any special diets that the person may need.
• The service worked in partnership with their local medical practice. Once every six weeks the GP undertook an extensive medicines review round.
• We met with the nurse consultant from the local medical practice. They undertook a "ward round" visit once a week where they saw all the people who lived at OSJCT Eresby Hall. They explained that the aim of their visits was to prevent hospital admissions, reduce calls to the GP practice, medicine management and to support people to remain at OSJCT Eresby Hall at the end of their life. They told us that they had built a good and trusting working relationship with the care staff and feedback was positive.
• Care staff shared information at shift handovers about individual care needs and overall wellbeing to maintain continuity of care. Two members of care staff signed to confirm that all relevant information had been passed on.

Ensuring consent to care and treatment in line with law and guidance
• The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf

of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

• People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

• We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met. On the day of our inspection eight people were being lawfully deprived of their liberty.

• Where a person had appointed a lasting Power of Attorney (LPA) to act on their behalf when they were no longer able to make decisions for themselves a copy of the document was kept with the person's care file.

• We saw that staff had sought support from an Independent Mental Capacity Advocate (IMCA), appointed by the local authority MCA and DoLS team. The IMCA represented the person, to act in their best interest as they had no-one else to support them and were unable to communicate their wishes.

• Staff understood the principles of MCA and sought consent from people for aspects of their care. For example, when a major decision, such as permanently moving into the service had to made, a best interest meeting was undertaken with the person and their family or representative. This recorded that staff were acting in the person's best interest.

Good

# Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity
• People and their relatives told us that they were well looked after. One person said, "The personal care is very good. "Another person told us, "[They are] so caring." A relative said, "They have really catered for what [name of person] needs and wants. Nothing is too much trouble. Since the beginning of the year the improvement [in their well-being] has been really good."
• People were cared for by kind, caring and compassionate staff. We observed staff assist people to walk from the lounge to take their place in the dining room for their lunch. Care staff first explained to the person what they were going to do and asked them if this was okay. They then walked at the person's own pace, and encouraged and praised them for their efforts.
• Staff were friendly and always smiling. They took time to ask people how they were or what they were doing when they passed through a communal area. We noted that people who were cared for in their bedroom were treated in the same pleasant manner.

Supporting people to express their views and be involved in making decisions about their care; Respecting and promoting people's privacy, dignity and independence
• People told us that staff respected them and supported them to make their own decisions and maintain their independence. One person said, "I live my life just like I did at home. I normally go to bed at 1 am or 2 am. I do not need much sleep. I was amazed that the staff were quite happy with that. It's my choice when I go to bed and when I get up."
• People were enabled to access an independent advocate if they wished. An independent advocate is a lay person, independent of the service and offers support and acts as voice for people who are unable to make decisions for themselves. For example, to make the decision to move into the service permanently.
• We saw that care records and personal files were stored securely and all computers were password protected. This meant that their confidential information was stored in compliance with the Data Protection Act and the General Data Protection Regulations (GDPR).
• Staff had taken great care to ensure that the dining room was a pleasant and homely environment, that enhanced the dining experience. Tables were set with linen tablecloths, place mats and fresh flowers. We noted that when a person was taking their meal in their bedroom, that they were afforded the same level of

dignity. Their meals were presented on a tray with a linen cloth, napkin and condiments.
• People were supported to sit in friendship groups and there was a lot of friendly chatter.
• There were ample communal sitting areas throughout the service, such as lounges and quiet corners in the corridors. People could choose where they wanted to sit.

Good

# Our findings

Responsive – this means we looked for evidence that the service met people's needs

People's needs were met through good organisation and delivery.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
• People had their care needs assessed and personalised care plans were introduced to outline the care they received. Care was person centred and people and their relatives were involved in planning their care. We saw that individual care plans focussed on supporting a people to live well and maintain their optimum level of independence and well-being. For example, one person with long term breathing difficulties preferred to sleep in their reclining armchair at night. We saw that their care plan identified all their needs at night, including their window and door left open and their light switched off.
• The registered manager had introduced "the resident of the day" initiative. Each person had a day once a month that was centred on them. All their risk assessments and care plans were reviewed and updated. The person had their bedroom deep cleaned, the head chef discussed their dietary needs with them and their key worker chatted with them in depth about what the service could do better for them. A senior member of care staff told us that the whole process was person-centred and focussed on the person as a unique individual.
• We found that when a person had a new episode of ill health that a care plan was written to enable staff to provide care and support that met the person's changing care needs. For example, when a person with a long-standing health condition acquired an acute infection that they were prescribed antibiotics.
• People were supported care staff and volunteers to maintain their hobbies and interests and enabled to develop new ones. We observed some people taking part in fresh flower arranging. The floral arrangements were put on the tables for lunch. After lunch people were supported to play games and join in a sing song.
• Family and friends were encouraged to support people to maintain their interests in the community. We saw that one person was visiting a garden centre and another person had gone for a drive with their relative.
• A strong network of volunteers supported people to follow their hobbies, pastimes and accompany them on visits into the local community. A senior member of care staff praised the volunteers and said, "They are like an extended family, are all local and have a good relationship. They are very instrumental in doing activities, while we are busy caring."
• Two volunteers had introduced a regular "drinks and nibbles" event before Sunday lunch. People told us that they looked forward to these events and one person said, "I quite enjoy my drink before Sunday lunch. Just like my husband and I used to do at home."
• We saw that staff and people who lived in the service respected peoples' religious, cultural and spiritual

beliefs and supported them to follow the faith of their choice. For example, religious services for different Christian faiths were held every two weeks. One person was accompanied by a volunteer to attend their church every week and another person who had been a missionary overseas received a daily visit from a member of their church. Staff had received training in equality and diversity and understood how to use this knowledge to reduce any possible barriers to care.
• We found evidence in individual care files that the service had taken steps to meet the Accessible Information Standard (AIS). All providers of NHS care or other publicly-funded adult social care must meet the AIS. This applies to people who use a service and have information or communication needs because of a disability, impairment or sensory loss.
• The provider had acknowledged the special needs and care that a person living with dementia and their relatives required and had appointed Admiral nurses to provide expert clinical, practical and emotional support. We spoke with a visiting Admiral nurse who told us how their role helped staff and families better understand dementia and improve the overall wellbeing of the person.

Improving care quality in response to complaints or concerns
• People and their relatives had access to the complaints policy and procedures that signposted them to external agencies such as the Local Government Ombudsman.
• The provider maintained a record of all complaints and compliments received. We saw that complaints were fully investigated and resolved in a timely manner. For example, we found that proactive action had been taken to resolve a communication issue. One person's relative lived in a different time zone and care staff had failed to notify them of an incident with their loved one. The time difference made telephone communication difficult. Therefore, to ensure effective and timely communication, the relative now received a daily email update on their loved one's well-being.
• Staff told us that they would escalate any complaints or concerns shared with them to the registered manager.

End of life care and support
• Staff understood the importance of supporting people and helping them prepare for care at the end of their life according to their wishes. People were supported to record their final wishes and preferences on an advanced care plan, such as where they wanted to die and their funeral wishes. However, we found that some people found that the time had not yet come to record their wishes and their choice was respected.
• Some people had a made the decision not to be resuscitated if their heart was to suddenly stop beating. We saw that the proper documentation had been completed by a competent healthcare professional, such as their GP.

Good

# 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

The service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
• At our last inspection in December 2017 we found that the provider had not ensured reporting arrangements for care staff to escalate incidents which placed people at risk were sufficiently robust. On this inspection we found that the provider had taken appropriate action to address this.
• Staff held the registered manager in high regard. One senior member of staff said, "[Name of registered manager] has insanely high standards. She will preach until she is blue in the face to raise the standards." Another member of staff said, "Can't fault [name of registered manager]. She is understandable and approachable. We get positive feedback. She praises us."
• All the staff we spoke with said the home had improved significantly in the last year and this was down to effective leadership. One staff member said, "We have a full senior team and we are going from strength to strength. We couldn't hope for a better management team."
• It is a legal requirement that a provider's latest CQC inspection report is prominently displayed. This is so that people living in the service and those seeking information about the service can be informed of our judgments. We noted the rating from the previous inspection was displayed at the main reception area and on the provider's website. In addition, the registered manager's certificate was on display.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility
• People and their relatives told us that they knew the registered manager, that they were approachable and could turn to them with any problems or complaints. One relative said, "If I have a query I email the manager and they always reply."
• The provider promoted a positive culture where staff were supported, respected and valued by management and each other. Staff told us that the registered manager was approachable and the service was a good place to work.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

• The registered manager led a daily session called "10 at 10". This was a 10-minute meeting held at 10am with the head of care, a senior member of care staff, and representatives from the housekeeping team, catering staff, maintenance and the administrator.

• We observed this meeting. Staff shared updates on matters relevant to people in their care and the smooth running of the service: the daily menu, staff training, health and well-being and planned activities.

• The registered manager told us that people and their relatives had a say in the running of the service through regular meetings and an annual survey. People confirmed that they attended meetings and had a say in the running of the service. One person said, "We have residents' meetings now and again, asking about things we like and dislike." A relative said, "Surveys do get sent out. I usually help [name of person] to fill them in."

• Meetings were held with all staff from all areas and disciplines within the service. We saw the minutes from recent meetings with housekeepers, all care staff and senior staff. The topics discussed were relevant to the care that people received from each staff group. We noted that staff had a voice at these meetings. One member of care staff told us, "As carers we have a say. We speak up and change happens. The manager and head of care implement what has been said."

• The meeting minutes were on display in the staff room so as staff who were unable to attend could read them.

Continuous learning and improving care

• Staff had access to policies and procedures that reflected current CQC regulations, national guidelines and up-to-date research. The policies we looked at were clear, concise and easy to follow. Staff told us that they could access the policies and procedures from both the registered managers and care staff office. One member of care told us that they were accessible and said, "They are very informative and not too wordy."

• The provider had introduced a new framework for supervision and appraisal for all staff called, "Trust in Conversation." We looked at the records from three recent supervisions and saw that staff were involved in identifying their achievements and development needs and objectives were set relevant to those needs. The feedback from staff was positive.

• There was a process in place for staff to report an accident or incident. These were investigated and reviewed by the manager who shared them with the provider. Staff received feedback on the incident, the outcome and any actions to be taken.

• There was a robust clinical governance programme that measured the effectiveness of all aspects of the service that had an impact on the people who lived there. The provider measured the effectiveness of the service against the five domains used by CQC; safe, effective, caring, responsive and well-led. Any identified areas for improvement were actioned, and where necessary, individual care plans were amended to reflect this.

Working in partnership with others

• The registered manager had forged links with the local community. Students from a local school for young people with a learning disability had work experience in the service. We found that this was of mutual benefit to students and people who lived in the service.

• The registered manager and their team work in partnership with their local clinical commissioning group and the local authority contracting team