Bikur Cholim Ltd

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Inspection report

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Date of inspection visit:
17 April 2018

Date of publication:
24 May 2018

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

We inspected Bikur Cholim Limited on 17 April 2018. The inspection was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in. Our last inspection took place on the 24 November 2016 and we found one breach of regulation in relation to safe care and treatment. At this inspection we found some improvements had been made.

Bikur Cholim Ltd is a domiciliary care agency. It provides personal care to people in the Jewish Orthodox community living in their own houses and flats in the community. At the time of the inspection it was providing a service to 50 people.

There was not a registered manager at the service at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. A new manager had started in the role and they had begun the process to apply for the position of the registered manager.

Risk assessments were in place which provided guidance on how to support people safely. However some risk assessments still lacked detailed. After the inspection the service sent us updated risk assessments which provided more detail. We have made a recommendation about assessing the risks to people.

People and their relatives told us they felt the service was safe, staff were kind and the care received was good. We found staff had a good understanding of their responsibility with regard to safeguarding adults.

Medicines were managed in a safe manner. There were sufficient numbers of suitable staff employed by the service. Staff had been recruited safely with appropriate checks on their backgrounds completed. Staff undertook training and received regular supervision to help support them to provide effective care.

Care plans contained detailed information and clear guidance about all aspects of a person's health, social and personal care needs, which helped staff to meet people's individual needs. Some of the care plans lacked detailed however staff had worked with people and their families for long periods of time and could describe in detail the care people needed. After the inspection the service sent us updated care plans which provided more detail.

Staff we spoke with had a good understanding of the Mental Capacity Act 2005 (MCA). MCA is law protecting people who are unable to make decisions for themselves. People who had capacity to consent to their care had indicated their consent by signing consent forms. However, where people lacked capacity to consent to their care the provider had not followed the principles of the Mental Capacity Act (MCA) 2005. We have made a recommendation about following the principles of the MCA.

People's cultural and religious needs were respected when planning and delivering care. Discussions with staff members showed that they respected people's sexual orientation so that lesbian, gay, bisexual, and transgender people could feel accepted and welcomed in the service.

The service had a complaints procedure in place. People and their relatives knew how to make a complaint.

Staff told us the manager and senior staff were approachable and open. The service had various quality assurance and monitoring mechanisms in place.

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. Staff were able to explain to us what constituted abuse and the action they would take to escalate concerns.

Risk assessments were in place which set out how to manage and reduce the risks people faced.

Medicines were recorded and administered safely.

Staff were recruited appropriately and adequate numbers were on duty to meet people's needs.

People were protected by the prevention and control of infection.

Is the service effective?

Good

The service was effective. Staff had received the training and support they needed to perform their roles.

People's needs had been assessed and care planned in a person-centred way.

Staff had a good understanding of the Mental Capacity Act 2005 (MCA).

People were supported to eat and drink in line with their preferences.

The service worked with other services and healthcare professionals involved in people's support.

People were supported to have their routine healthcare needs met.

Is the service caring?

Good

The service was caring. People and their relatives told us that they were well treated and the staff were caring. People could make choices about how they wanted to be supported and staff listened to what they had to say.

People were treated with respect and the staff understood how to provide care in a dignified manner and respected people's right to privacy.

Is the service responsive?

Good

The service was responsive. People's needs were assessed and care was planned in line with the needs of individuals. People and their relatives were involved in planning their own care.

The service had a complaints policy and complaints were resolved in line with the policy.

People's cultural and religious needs were respected. Staff members showed that they respected people's sexual orientation so that lesbian, gay, bisexual, and transgender people could feel accepted and welcomed in the service.

The service had clear systems in place to ensure people received appropriate care at the end of their lives.

Is the service well-led?

Good

The service was well-led. Staff told us they found manager and senior to be approachable and there was an open and inclusive atmosphere at the service.

The service had various quality assurance and monitoring systems in place.

The service worked in partnership with key organisations to support care provision, service development and joined-up care.

Bikur Cholim Ltd

Detailed findings

Background to this inspection

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

This inspection took place on 17 April 2018 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in. The inspection team consisted of one inspector.

Before we visited the service we checked the information we held about the service and the service provider. This included any notifications and safeguarding alerts. A notification is information about important events which the service is required to send us by law. The inspection was informed by feedback from professionals which included the local borough contracts and commissioning teams that had placed people with the service, and the local borough safeguarding adult's team. We reviewed the information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

Before the inspection we spoke with three people who used the service and 13 relatives. During our inspection we spoke with the manager, the chief executive, the care manager and four care workers. We looked at five care records, medicine records, five staff files which included supervision records, appraisals and recruitment records, quality assurance records, minutes for various meetings, accidents and incidents records, training information, policies and procedures, and complaint information.

Good

Is the service safe?

Our findings

At the last inspection in November 2016 we found the service was not always safe. We had identified breaches of regulations regarding people's medicines not always managed in accordance with safe procedures and risks to people were identified however these were not always thoroughly assessed to show how these risks were managed. We found medicines were now being managed safely. People's risks were being identified however some improvements were still needed.

People's care files included risk assessments which had been conducted in relation to their support needs. Risk assessments covered areas such as the home environment, medicines, moving and handling, equipment, infection control and lone working. Most risk assessments were specific to the individual and included information for staff on how to manage risks safely. For example, one person was diagnosed with a low immune system which put them at risk of infection. The risk assessment gave guidance about how to support this person at home with detailed instructions on infection control procedures. However some risk assessments lacked some detail about how to mitigate risks. For example, one person was at risk of malnutrition. The risk assessment gave minimal guidance why this person was at risk other than encouraging the person to eat and drink at all care visits. However staff we spoke with were familiar with the risks that people presented and knew what steps were needed to be taken to manage them. Also the provider had a manual handling template available however this was not being used. We spoke to a senior staff member about the manual handling template and they were unsure why they had stopped using it. They advised us they would start using the template for future assessments of people. After the inspection the service sent us updated risk assessments which provided more detail.

We recommend the service seeks and follows best practice guidance from a reputable source about assessing the risks to people.

People and their relatives told us they were supported with their medicines. One person said, "Staff do the meds for me." A relative told us, "Meds and vitamins are given and [staff member] writes down what is given." The service had a medicines policy in place which covered the recording and administration of medicines. It stated that staff had to undertake training before they were able to administer medicines and records confirmed this was done. Medicine administration record charts were in place where the service supported people to take medicines and these contained details of each medicine to be given. Staff signed the charts after each administration so there was a clear record that the person had received their medicine. The medicine records were returned to the provider's office monthly. The medicine records were checked by a senior member of staff to ensure they were completed correctly once they had been completed. We saw that where issues were found they were addressed with the relevant staff member. Medicine records we looked at were accurate and up to date. One staff member told us, "In the house we have all the information on the client like with medicines. Every month we get a new medicines sheet. We always bring back the old one."

People who used the service and their relatives told us they felt the service was safe. One person said, "I feel very safe. Very safe when I have a shower. [Staff member] tests the water for me and [staff member] keeps

me warm." A relative said, "Definitely feel safe. [Staff] careful how they move [relative] from wheelchair to bed. They make sure [relative] hasn't any sores. No incidents of falls. [Relative] has brittle bones and they have to be gentle how they handle [relative]." Another relative told us, "I do feel safe. I've left [relative] alone with [staff] in the house and everything's been fine. I know [relative] is safe and well looked after."

Staff knew what to do if there were any safeguarding concerns. They understood what abuse was and what they needed to do if they suspected abuse had taken place. Staff told us they would report any witnessed or suspected abuse to the manager and senior staff. All staff had received up to date training in safeguarding adults from abuse. The organisation's whistleblowing policies and procedures were also contained in the staff handbook which was given to all new members of staff when they first joined the service. One staff member told us, "I will inform my manager first and they will take action. If they don't take action I would inform social services." A second staff member said, "I would tell the manager." Staff were aware of their rights and responsibilities with regard to whistleblowing.

Records showed there had been no safeguarding incidents since the last inspection. The manager was able to describe the actions they would take when an incident occurred which included reporting it to the Care Quality Commission (CQC) and the local authority safeguarding team. The manager said, "I would investigate. Any concerns I would notify CQC and social services." This meant that the provider would report safeguarding concerns appropriately.

Accident and incident policies were in place. Accidents and incidents were documented and recorded and we saw instances of this. We noted incidents were responded to in a timely fashion and outcomes and actions taken were recorded. The service had one incident since the last inspection, whereby a person had physically assaulted a staff member. As a result the service contacted social services and the relatives to help support the person more safely. There had been no further incidents for this person. This meant the service learned from incidents and put procedures in place for prevention.

Through our discussions with the manager, staff, relatives and people who used the service, we found there was enough staff to meet the needs of people who used the service. Staffing levels were determined by the number of people using the service and their needs, and could be adjusted accordingly. Staff told us they had enough time between visits to be punctual and their shifts were covered when they were on sick and annual leave. One person told us, "My carer does the full time allocated. I never feel rushed. [Staff member] does what she can in the time allocated. Sometimes she finds time to tidy up my room and make it presentable." A second person said, "[Staff] come on time. Sometimes five to ten minutes late. I have had the same person for a long time. They support me well and they never rush." A third person told us, "Never had a time [staff] have not turned up." A relative said, "[Relative] has about four carers. Generally they tell me if they're running late." Another relative told us, "If the carer can't come they will try and place a new carer. They always make sure there's somebody to cover."

The service had an out of hours on call system available. A staff member told us, "You can call 24 hours." Each person had the out of hour's number available to them in their home. One person told us, "I would call the mobile number I have." A relative said, "I would call the mobile number given if the office is closed." This meant staff and people who used the service could get assistance, advice and support if needed outside of office hours.

The provider followed safe recruitment practices. Staff recruitment records showed relevant checks had been completed before staff worked unsupervised at the service. We saw completed application forms, proof of identity, references and Disclosure and Barring Service (DBS) checks. The DBS is a national agency that holds information about criminal records. One staff member said, "I had an interview and had to bring

all my documents. They did a criminal check before I could start working." This meant the provider had done all that was reasonable to ensure people were suited to working in the caring profession.

Staff told us they were provided with personal protective equipment in order to ensure people were protected by the prevention and control of infection. Staff told us they could collect gloves and aprons from the office. Records showed staff completed training in infection control and prevention. One person told us, "[Staff] clean and hygienic." Another person said, "[Staff] have jobs like washing the commode and they clean and disinfect."

Good

Is the service effective?

Our findings

People and their relatives told us they were happy with the service they received and felt staff had the skills and experience they needed to provide them with effective care and support. One person said, "[Staff] do their job well." A relative told us, "[Staff] are well trained, experienced and kind. They know what they are doing and they do it in kind and caring manner."

Before a person started to use the service a senior staff member would carry out an assessment of their needs, before an agreement for placement was made. This was carried out to ensure that the service could meet the person's needs. Records showed that an assessment of their needs had been carried out. Information was obtained from the pre-admission assessment, and reports from health and social care professionals had been used to develop the person's care plan. One relative said, "We discussed what was needed and the agency was accommodating." Another relative told us, "Yes [office staff] did come in. We went through the package of what we needed and I had a say in what we wanted." This helped staff to ensure that people received individualised care and support which took account of their wishes and preferences.

Staff were trained and supported to have the right skills, knowledge and qualifications necessary to give people the right support. A staff member told us, "I have had training on food hygiene, moving and handling, child protection and bed sores. We have a trainer explain everything well. They give questions after training about what we have talked about." Another staff member said, "I have a lot of training. It is very high quality." Staff we spoke with confirmed that they had received all of the training they needed. The training records and staff files we looked at confirmed that staff had received training for their role which would ensure they could meet people's individual needs. This included training in topics such as moving and handling, pressure sores, medicines, supporting individuals, health and safety, safeguarding, and the Mental Capacity Act 2005 (MCA). We noted first aid training had not been offered for the period of 2016 to 2017. After the inspection the provider sent us information advising first aid training would be completed by September 2018.

New staff joining the service completed the care certificate. The care certificate is a recognised qualification that ensures that staff have the fundamental knowledge and skills required to work in a care setting. When new staff joined the service they completed an induction programme which included shadowing more experienced staff. One staff member said, "I had induction. Before I went to the client [the office staff] explained everything. The carer showed me what to do."

Staff had regular one to one supervision meetings with a senior member of staff. One staff member said, "I got supervision a few weeks after I started. [Senior staff] ask about the clients." Another staff member told us, "Supervision is every few months. We talk about everything like about the client and what I need to learn." Records showed supervision included discussions about updates on people who used the service, training, safeguarding, health and safety, complaints, and equality and diversity.

People were supported to have sufficient food and drinks. Some people required support with their meals.

Care records showed how people's dietary needs were assessed, such as their food preferences and how they should be assisted with their meals. A relative told us, "Yes they do support with food. My [relative] shows what she wants to eat and they accommodate that." Another relative said, "Yes [staff] prepare breakfast, prompt her to eat and finish food." Staff spoken with during our inspection confirmed they had received training in food hygiene and were aware of safe food handling practices when supporting people in their homes.

Staff were aware of what action to take if people were unwell or had an accident. They told us they would contact people's GP or phone for an ambulance as necessary and inform people's next of kin. A member of staff told us, "I would inform the agency and next of kin if person not well. I have a special number for the ambulance." We saw that care plans included contact details of GP's and relatives. Records showed the service worked with other agencies to promote people's health such as diabetes specialists, dementia organisations and a local hospice.

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.

Consent to care and treatment forms were in care plans signed by people who used the service. Family were involved in making decisions where people lacked capacity. Staff demonstrated that they understood the principles of the MCA and the importance of seeking consent. One staff member said, "I always ask what dress they want to wear and what food they want to eat. They have a choice." One person said, "Yes [staff] do ask what is to be done." A relative told us, "[Staff] ask her permission and talk to her about it." Another relative said, "[Staff] talk through her care and tell her exactly what they are doing."

We found the service had up to date policies and procedures in relation to the MCA so that staff were provided with information on how to apply the principles when providing care to people using the service. Staff had received MCA training and they were aware of how the MCA applied within their day to day practice. The provider had a mental capacity assessment template with the MCA policy however they were not using this template. Senior staff told us they were given information about people's capacity from social services when the person joined the service. Senior staff said they assessed people capacity with their risk assessment process however this contained minimal information to accurately assess someone's capacity.

We recommend that the service consider current guidance on the Mental Capacity Act 2005 (MCA) and take action to update their practice accordingly.

Good

Is the service caring?

Our findings

People and their relatives told us they were well treated and the staff were caring. One person told us, "[Staff] are caring. The [staff member] I have got is caring even different ones are very good. They look after me." Another person said, "I've had the same carer for so long. I feel comfortable with her." A relative told us, "[Staff] are very warm and caring." Another relative said, "[Staff] care because when [relative] has been unwell they've said things and shown through their actions that they're worried about her." A third relative said, "[Staff] love my [relative] and she loves them. [Staff member] puts her heart into it." A fourth relative told us, "Always striving for the best quality care for my [relative]."

Staff told us that the people they supported had been with them for long periods of time so they knew them well. Staff spoke in a caring way about people they supported and told us that they enjoyed working at the service. One staff member said, "I like the job. I like looking after elderly people." Another staff member told us, "It's a pleasure to work with people." The same person said, "The relationship I have with the family is amazing." A third staff member said, "I like to help people."

Care plans contained information about people's communication needs and preferences. This helped give staff the information they needed to build rapport with people in order to establish positive relationships with them. For example, one support plan stated, "I need people to have patience when I speak." The provider continued this supportive approach in the way they introduced care workers to the people they cared for. Staff confirmed they visited people and completed shadowing before being allocated to work with people on a permanent or replacement basis. People had a preference for care workers of a specific gender and people told us this was respected.

Care plans also contained a section called, "These things are import to me." This included information about people's background, personal history, family and friends, home life, pets, routines, cultural and religious preferences, and how they liked to spend their time.

People were supported to express their views and to be involved, as far as possible, in making decisions about the care and support they received. Senior staff explained they had their own voluntary advocacy service they could refer people to if they wished. The provider had considered people's individual needs when planning for the service. For example, the service is operated by a charity and therefore they had been able to fund additional hours for people to receive care and support that fully met their needs.

People and their relatives told us their privacy and dignity were respected. One person said, "I am treated with dignity." A relative told us, "Before [relative] comes out the bath [staff] have to close the blinds and doors." Another relative said, "[Staff] treats my [relative] as a human being with dignity and respect." Staff we spoke with gave examples about how they respected people's privacy. One staff member told us, "Always provide care in private. Never give information about private things they talk about." A second staff member said, "I close the door and windows so no one sees."

The service promoted people to live as independently as possible. Staff gave examples about how they

involved people doing certain aspects of their own personal care to help them become more independent. This was reflected in the support plans for people. For example, one support plan stated, "I can brush my own teeth and hair. I like to choose my own clothes every morning." One staff member told us, "[Person who used the service] is very independent and fights for her independence. There are moments she can do things. I am glad when she can do things and has a new experience."

Good

Is the service responsive?

Our findings

People and their relatives told us the service was responsive to people's needs. A relative said, "The carer is there to help [relative]." Another relative told us, "[Relative] has different needs and [staff] deal with needs well. The carers are patient." A third relative said, "[Staff] understand [relative's] needs, which is a great help to me."

Care plans contained detailed information and clear guidance about all aspects of a person's health, social and personal care needs, which helped staff to meet people's individual needs. The support plans covered medicines, nutrition and meals, mobility, mental health, daily living, relationships, local community, communication, leisure, learning and work. The care plans were person centred. For example, one care plan detailed how someone wanted to be supported with personal care. The care plan stated, "As I cannot use my right hand I need help with my dressing, showering and preparing my toothbrush." Some of the care plans lacked detailed however staff had worked with people and their families for long periods of time and could describe in detail the care people needed. One person said, "I know [staff] and they know me. They've got to know me well." After the inspection the service sent us updated care plans that contained more detailed information to support people who used the service.

People's care and support was planned proactively with them and the people who mattered to them. Relatives were fully involved, where appropriate, in identifying people's individual needs, wishes and choices and how these should be met. They were also involved in regular reviews of each person's care plan to make sure they were up to date. Records confirmed this. One person said about the care plan review, "I was definitely involved with it." A relative told us, "I was involved. [Office staff] tried their best to accommodate." Detailed support plans enabled staff to have a good understanding of each person's needs and how they wanted to receive their care.

Staff were respectful of people's cultural and diverse needs. They were given a 'guide for carers' before they began work. The guide was developed to advise staff on how best to support people from the orthodox Jewish community and how their needs should be met. Staff confirmed they had received training to support this. The guide included information on kosher foods, Shabbos, modesty, festivals, family relationships, end of life care and supporting people who were Holocaust survivors. One staff member told us, "I worked in Israel for five years working with Jewish people. At training we find out people's religious needs." Another staff member said, "We talk about Jewish people's culture. [Senior staff member] explained about the culture." One relative told us, "[Staff members] do ask me about the service. The service is Jewish and relates to our culture."

Discussions with staff members showed that they respected people's sexual orientation so that lesbian, gay, bisexual, and transgender people (LGBT) could feel accepted and welcomed in the service. The manager told us, "It wouldn't affect how we give care." A staff member told us, "We would treat them the same." Another staff member said, "Doesn't matter if you are gay or lesbian. I am open to everyone." Training records showed staff had completed equality and diversity training.

The provider had a system in place to log and respond to complaints. There was a complaints procedure in place. This included timescales for responding to complaints and details of who people could escalate their complaint to if they were not satisfied with the response from the service.

People and their relatives were aware of how to make a complaint. One person told us, "On the whole I'm happy so no need to complain. I would call the mobile number given if I had to make a complaint." A relative told us, "I would call the office. I've had to make a complaint in the past and they tried their best to resolve it." Records showed the service had received 15 informal complaints since the last inspection. We found the complaints were investigated appropriately and the service had provided a resolution for the complaint in a timely manner.

At the time of our inspection the service did not have any people receiving end of life care. The manager told us the service worked with palliative care teams, a local hospice and the GP when people were at end of life. The service had an end of life policy which was appropriate for people who used the service. The end of life policy covered topics such as companionship, comfort, nutrition, pain management, and social relationships. One staff member said, "I had one person who passed away. You try your best. I cleared her mouth and changed her position. I talked to her." We saw cards of thanks and appreciation from relatives in relation to the end of life care provided to people who had used the service. The cards showed how staff had supported people with kindness.

Good

Is the service well-led?

Our findings

People who used the service and their relatives told us they had regular contact with the manager and the office staff. One relative said, "[Manager] very friendly and very competent." Another relative told us, "I find [manager] supportive."

People's feedback regarding the service was very positive. One person said, "So far I am pleased, but everyday they help in many ways. No complaints. [Staff] give me whatever I need and never refused." A relative told us, "The agency are very efficient, very formal, respectful and very helpful and happy to accommodate as much as possible. If they can't help they'll try and direct me to the right place."

The service did not have a registered manager at the time of our inspection as they had recently left the role. A new manager had started in the role and told us they had started the process to apply for the position of the registered manager. After the inspection we received a notification that the application process had begun.

Staff spoke positively about the manager and the senior staff. They said they felt comfortable raising concerns with them and found them to be responsive in dealing with any issues raised. One staff member told us, "The manager [role] is a difficult job. [The manager] knows to listen. That is very important. She finds the best solution. I feel very close to her and that is important in my job." A second staff member said, "[Care managers] are both very good. If I ask something they will do their best." A third staff member told us, "Any problems you can call. You get a quick answer. I like them [senior staff]." A fourth staff member said, "[Care manager] very good. If any problems they help me."

Staff meetings were held regularly. Records confirmed this. Topics of meetings included care plan reviews, training, CQC requirements, medicines, and supervision.

The service involved people and their relatives in various ways and sought feedback on the service provided. This included regular reviews with people and relatives, and an annual survey. Spot checks included visiting people in their home and telephone calls to people and their relatives. Records confirmed this. The spot checks topics included overall satisfaction, care plans, respect and punctuality. One comment from a spot check, "I am very pleased and have no complaints. My carer is very respectful and reliable." One person told us, "[Office staff member] came out two months ago and spoke to me. [Office staff member] came before [Jewish holiday] to check about staff and feedback."

The quality of the service was also monitored through the use of annual surveys to get the views of people who used the service and their relatives. The last annual survey was conducted in January 2018. Records showed 45 surveys were sent out and 32 were returned. Overall the results were positive. One person said, "I've done a paper survey [about] staff performance and the service." A relative told us, "I get sent surveys. [Office staff] call me and ask how I'm finding the service." The questionnaire for people who used the service and their relatives included questions about overall satisfaction, complaints, care plans, positive changes in my life and feeling safe. Returned surveys were positive. Comments included, "I am not alone all day. I now

prepare my own sandwiches for lunch as my care worker has coached me in doing this", and "My care worker helps me make my own choices."

The manager told us she had developed a monthly audit tool that would look at the number of care plan reviews, risk assessment reviews, missed and delayed visits, complaints, safeguardings and other notifications. The manager told us the audit tool would start from May 2018. After the inspection the manager sent us the monthly audit tool.

The service worked in partnership with key organisations to support care provision, service development and joined-up care. For example, the manager told us the service had worked with a local hospice so they could meet the needs of Jewish Orthodox people. Also the service had established a quarterly forum with the local hospital to share information about the needs of the Jewish community receiving healthcare. The service worked with national dementia association, local hospice and palliative care teams, and the local authority commissioning team. A health and social care professional told us, "Their senior management are available and clear in their communications when they want to discuss issues."