Safe pathways, systems and transitions

Score: 2

2 - Evidence shows some shortfalls

What people expect:

When I move between services, settings or areas, there is a plan for what happens next and who will do what, and all the practical arrangements are in place. I feel safe and am supported to understand and manage any risks.

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The local authority commitment:

We work with people and our partners to establish and maintain safe systems of care, in which safety is managed, monitored and assured. We ensure continuity of care, including when people move between different services.

Key findings for this quality statement

Safety management

There were systems in place to manage risks to people across their journeys, including referrals, admissions, discharge, and where people were moving between services. However, improvements were needed to ensure continuity across transitions from children to adult pathways.

Systems were in place for access to referral pathways and safeguarding teams during out of office hours and in emergency situations. The out of hours service was an all-age team, which provided mental health act assessments, adult safeguarding responses and child protection as their priority work. The service had suitably trained call handlers to identify the required action and to make the appropriate onward referral.

Safety during transitions

The local authority routinely commenced working with young people aged 16 to support them with the transitions to adult services. Adult social care social workers also attended education, health, and care plan reviews for young people. For mental health services for young people, transitions from children and adult's services started at 17 and the children's and adult's social worker completed the assessment together.

The local authority also worked with young people who did not meet the criteria for the preparing for adulthood team. This could be autistic people or people with a learning difficulty presenting with new needs and without special educational needs. The local authority began working with these young people from the age of 18.

We received mixed feedback from people about their experiences of moving between children and adult services. We were told about a smooth transition without any delays. The person had been contacted when they were 17 years old which enabled the social worker to develop a relationship with them and their family prior to the person becoming 18. Another example was a successful move to a new placement as the social worker had liaised with the provider to match the correct staff, so that the person had a choice of who they wanted to live with, and the environment had been adapted for their needs.

Information reviewed from the local authority showed that one person who has transitioning from children's to adult services, was allocated an adult social worker just prior to the person reaching 18 years of age. The person told us they felt this had a negative impact on them and their family in terms of care planning and continuity. The local authority confirmed their aim is to work with people from an earlier age but acknowledged this had not happened in this case.

A partner organisation told us they felt the local authority system was not joined up in terms of planning for a young person's future at the point of transition into adult services, or if they had a learning disability. They told us they were able to raise their concerns with the local authority through involvement in strategic forums and the Making it Real Board.

Staff gave positive examples of how they had supported young people to become more independent and supported another young person to move from the family home into supported living. This had a positive impact for the person, and they increased socialising with others.

Overall, the feedback from providers was positive on the role of the local authority supporting people when they needed to move between services. They told us there was a structured process for people moving from home or from one care home to another care home.

There were several pathways used for discharging people with support needs to care services, when leaving hospital. These included reablement, domiciliary care, short term placements and long-term placements. The local authority and health partners worked together in a multi-disciplinary approach to provide a 7-day hospital discharge model. There were daily meetings with health and social care staff to identify plans for discharge and to inform the transfer document used for sharing information on discharge from hospital. People discharged with support services were reviewed by a social work team.

There was a process for reporting problematic discharges to a joint 'discharge alliance group'. The alliance undertook deep dives into the issues to drive continuous improvement and work as a system in achieving positive outcomes for people. The local authority provided an example of how this had led to an improved discharge experience for an individual. Some people told us they had experienced a positive discharge from hospital and that the handover of care between the reablement service and a long-term care provider had worked well.

Some care providers reported a good relationship with the local authority, and they felt they could speak to them and come to decisions quickly. An example given was when an emergency care home placement was needed with specialist care and the person receiving the care had a swift and easy transition. However, in contrast to this we heard that communication was at times poor with social work teams.

Contingency planning

The local authority had contingency plans in place to ensure preparedness for interruptions in the provision of care and support. The provider failure risk report outlined all the appropriate support to be made available and identified risks in this event.

The draft Business Continuity Management Tactical Recovery Plan – Adult Services (October 2023), provided guidelines to help staff analyse the impact of the incident on their service, implement the appropriate solutions and ensure the continuity of service activities.

Staff working with providers told us they had a good contingency and emergency plans in place. An example was given in relation to areas that flood within the local authority. Conversations and plans had been put in place with the people using the service about how they would like to be evacuated. Care providers told us on one occasion due to flooding, a paid carer was unable to get to the person receiving care and the local authority assisted with this and ensured the person receiving care was supported.

Staff described contingency planning as a focus and being a critical part of the assessment process and the information about contingency plans was also kept at the top of the person's care records so it was easy for staff to access. However, people told us this was not always completed and person-centred information about what should happen in an emergency was sometimes missing.
