Safe pathways, systems and transitions

Score: 3

3 - Evidence shows a good standard

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

The local authority understood the risks to people across their care journey. Staff spoke confidently about the handover process in hospital discharges for people at high risk. They used transition handover meetings with the locality teams and arranged for services including locality and outreach to come into hospital to meet people prior to their discharge. Risk assessments were completed, and this information was accessible to staff. Systems were in place for teams working out of hours. The out of hours team was led by neighbouring local authority Kent under a service agreement and there was a clear process in place to manage risk and sharing of information with Medway local authority.

At the time of the assessment senior leaders told us a transformation hub would be operational imminently with the introduction of 20 beds within a community unit. The multi-disciplinary team would work in partnership to create the ideal pathway for each person to ensure the correct discharge process to meet their needs. The primary focus of these beds was to increase capacity, in turn ensuring the timely discharge of patients from hospital and to use the beds to determine and source long term care and support services for people.

Safety during transitions

Care and support were planned and organised with people, together with partners and communities, in ways which improved their safety across their care journeys and ensured continuity of care. This included referrals, admissions and discharges, and where people were moving between services.

Medway's Better Care Fund Plan had key priorities including improvement in discharge pathways to improve outcomes for people discharged from hospital and wider system flow. Patients could be discharged from an acute episode of care to the Multi-Disciplinary Integrated Discharge Team, with referrals to Wellbeing Navigation, or to the Carers Service, where appropriate. Home First was a multi-agency reablement response service supporting hospital discharge for people who were medically stable and had reablement potential. We heard a positive example where the local authority had been solution focused and the social worker had worked above and beyond to solve issues relating to the person moving to a service following discharge from hospital.

For hospital discharges, the brokerage team worked with social workers, the integrated discharge team, and families. Social workers identified which people could be discharged, and the brokerage team gave updates on availability of care home beds 3 times per day to the integrated discharge team and families. The Transfer of Care Hub started the day prior to the CQC local authority onsite assessment. This programme would establish if people needed to remain in hospital or identify the need to be discharged, requiring a long-term assessment.

Staff working with the Integrated Discharge team worked collaboratively across teams and used resources such as urgent response, Home First through Medway Community Healthcare, therapists, consultants, nurses, dieticians, speech and language therapists, and others. They advocated for the social model against the medical, and positive risk taking in hospital discharge for people going back into their own homes. They also worked with Medway's internal teams such as the homelessness pathway, mental capacity forum, and high-risk panel. Housing was noted as an area of potential delay with hospital discharges, so the local authority had introduced a housing post within the hospital discharge team to identify and address any housing needs for people. Senior leaders highlighted working with housing on a strategic level was an area for improvement.

There were no waiting times for assessments under the Integrated Discharge Team, however at times people were unable to be discharged due to waiting for placements/ availability in local care market. The team conducted daily reviews for waiting patients. Reablement and step-down beds were available, however staff said they were consistently filled. Front line teams were concerned the proposed Discharge to Assess beds (D2A) would not address the blockages in the system and were concerned people would block D2A rather than hospital beds. The Health & Care Partnership was targeting increased Home First services and step-down services to support discharge, and recognised there were difficulties in discharging people with complex issues. Partners were less positive about safe transitions between services.

We spoke to people who were in the process of moving from a Mental Health Hospital to a community-based service and felt they were informed of the process and the social worker updated them as and when needed. A person told us there had been a good plan in place to ensure their smooth transition from a Mental Health Hospital to a service. Their views on the service they were moving to had been valued and considered.

People who were being placed out of area within a specific geographic region were visited in person before they moved. For all out of area placements, the local authority contacted the host authority to establish if the provider was known to and used by them to determine if there were any sanctions placed on the provider or safeguarding concerns. The local authority reviewed people at 6 weeks, then annually or more frequently if required. Contact was maintained with the host authority to ensure the placement remained to the expected standard.

Medway had clear processes for staff to follow for young people transitioning to adult services. The Ofsted report dated July 2023 recognised for some children with disabilities transition planning was not started early enough. The local authority Transition team worked with young people from the age of 17 but had started to identify children from the age of 16 who would need support.

We received mixed feedback from people who were transitioning from children to adult's services. We heard an example of someone who was contacted the year prior to their final year at college to discuss their future transition and plans for support following college were agreed well in advance. In contrast an unpaid carer told us they had not received any meaningful or helpful information around what to expect for their child's transition from children to adult's social care.

The Transition team had good links to the children's team and local schools. The team were proud of their relationship with schools, which enabled them to better understand a young person's needs transitioning into adult social care services. The team set up 'One Stop' drop-in sessions with special educational needs colleagues where people could get advice and guidance from the team, and young people approaching transition knew where to get support. Staff also attended the Parent Carer Forum which enabled staff to link up with parents and carers for people who may be known to social care, but also those who might not be known. Staff told us young people had a consistent adult social care worker from the age of 17 to 27.

There were clear processes which followed the guidance in the Care Act 2014 regarding 'continuity of care' for anyone moving into or out of Medway. The local authority shared information and assessments, and ensured the individual received the same care initially on arrival in the new area until the new local authority carried out their own assessment.

A Combatting Drugs Partnership (CDP) established by Medway Public Health had, as one of its priorities, to review, evaluate, and strengthen drug and alcohol treatment services to ensure there was better integration of services. There was a particular focus on the transition pathways for people with co-occurring conditions.

Providers were surveyed around safe transitions between services. The majority of providers felt they had not been included and had not received information. Providers acknowledge the local authority was improving approaches with them to ensure people receive coordinated, safe support when moving between different services. However, some providers still found needs assessments undertaken were not as accurate as they should be. They reported it was extremely difficult to get people moved if they had been placed with a provider who could not meet the person's needs, and communication could be improved.

Contingency planning

The local authority had contingency plans in place to ensure preparedness for possible interruptions in the provision of care and support. For example, the Business Continuity Management Plan set out the responsibilities and actions to be taken by staff to maintain critical functions in the event of a disruption affecting the service, and to reinstate, within a structured timeframe, a return to normal.

There was joint working between Medway's Quality Assurance, Adults Partnership Commissioning, (APC) brokerage, and safeguarding teams to share or identify concerns and the planned actions to address them. The Quality Assurance team kept a dashboard of concerns. Repeated concerns about a care provider would trigger an APC evaluation of them. The Contingency and Emergency Preparedness Plan identified recovery options in the event of service provider failure. The plan was implemented when a care home was at risk of closure, or when a care home closed, to ensure there was no disruption to services. The local authority also reviewed providers' own business continuity plans and as of 1 April 2024, the local authority had reviewed 96% of providers' plans.