# 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

The local authority understood its role in keeping people safe, however, systems were not fully embedded to allow full oversight and monitoring of risk. Leaders told us the introduction of a newer version of their Power BI Data monitoring system would help improve knowledge and oversight across adult social care. However, this system was not yet in full use. Leaders and staff told us knowledge of risk and the themes and trends relating to risk was often held by managers of individual teams however, this was inconsistent across teams. Staff told us there was very little oversight of this from a strategic level at this time. Leaders told us the practice forum and legal surgery supported staff with oversight of more complex cases and risks to people. The legal surgery was set up in March 2023 to support staff to have access to legal, mental health and safeguarding advice for complex cases. Leaders told us all cases which were presented to the legal surgery were audited to provide assurance.

Staff told us once cases were allocated it was their responsibility to monitor the risk of their caseload and they would discuss this in their supervision however, staff told us they were unsure what happened with this information after supervision. The local authority had recently recruited a PSW to support this oversight. However, this was a newly recruited role and therefore had not had time to embed any changes or oversight at the time of assessment. Staff and Leaders told us communication had improved since the PSW was in place. Staff were building trust and often went to the PSW for guidance, advice and support. This also helped bridge the gap between frontline staff and strategic leads.

Staff told us the limited access to other systems in integrated teams meant there was a risk of information getting lost and not being passed through the correct channels. For example, different health and local authority systems meant health could not always identify if someone was already known to ASC and what support was in place. OTs told us they were unable to access health systems, and this led to delays in assessments for people requiring equipment, which could result in people needing more care and support. Leaders told us they were aware of these concerns and were looking at ways to improve communication between systems.

Partnership working and joint policies and processes with health and voluntary and charity organisations enabled the local authority to share the responsibility for supporting people through their care journey. Partners told us risks were mitigated through joint working and early intervention, promoting independence and advocacy, this included strong links with the emergency duty team.

## Safety during transitions

The local authority had arrangements in place to ensure safety during transitions and continuity of care provision. The local authority had recently undergone a transfer of staff in which ASC staff were brought back into the local authority from a commissioned service. Staff told us the physical transfer was smooth and that people using services were not impacted by the move as their workers remained the same throughout the process. However, some staff felt the process had meant they had increased workloads and changes to their job roles which had impacted on their wellbeing and ability to carry out their role effectively.

The process for hospital discharge had changed and staff told us they no longer visited the wards to support hospital discharge and felt this could have a negative impact on the discharge process, as people may be sent home without the correct support in place putting them at risk of further hospital admissions. Partners told us since the decommissioning of the D2A bedded unit from the ICB, hospital discharge had been more difficult, and people were being placed in settings that were not always appropriate because they had the space to facilitate a hospital discharge. This meant people could be placed in settings that were not able to appropriately meet their care needs. One provider told us how one person was discharged to a care home and later identified they were unable to meet that person's needs due to the complexity of their needs, putting that person at increased risk of harm due to not receiving appropriate care and support. The local authority told us of actions taken to improve and support hospital discharge using the "home is best" approach such as the interim care pathway available both in care homes and in people's own homes. The local authority also jointly commissioned care journey coordinators to support people to return home whilst waiting for a longer term care package.

The local authority had a clear process for transitions, however, current staffing levels meant there could be delays in supporting people transitioning from children to adult services. The local authority had recruited some new staff to work in transitions and was awaiting their start date at the time of our assessment. Feedback regarding transitions for young people transitioning to adult care was mixed. One person told us that referrals to the preparing for adulthood team were made in a timely manner and communication was good. Whilst some carers told us they felt the transition between adults and children's needed to improve and that communication between children's services, adult services, and education was poor at times and had resulted in one person missing out on opportunities to promote their independence. The transition from children to adult services started at around 17 years old although staff told us this could be sooner for more complex cases and maybe after the person turns 18 in some cases.

## Contingency planning

The local authority undertook contingency planning to ensure preparedness for possible interruptions in the provision of care and support. This was demonstrated in the Community Risk Register. It included multi-agency information, procedures and actions to be taken to ensure an effective, timely response to any localised or major incident, which potentially could impact on people's safety.

The local authority undertook contingency planning to ensure preparedness for possible interruptions in the provision of care and support. A provider failure policy was in place to ensure quick and efficient provision of alternative care for people and their carers when needed. However, carers told us they found it difficult to access respite provision in an emergency to prevent carer breakdown.

Commissioning processes ensured access to services in a timely manner, however, access to specialist services was more limited. The local authority had identified there was a lack of local provision for young people moving into adult services. Leaders told us they continued to work collaboratively with commissioning and housing colleagues and ASC had supported and engaged in the development of the 10-year strategy with their housing association strategic partner to improve this provision in the future.

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