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 the importance of safety and the risks people faced across their care journey. They identified and mitigated risks to safely manage peoples' care. The Safeguarding Adults Board (SAB) provided measurement and monitoring of safety processes on a regular basis. The views of people who used services, partners and staff were listened to and considered by the local authority.

The local authority had systems and planning in place to respond to seasonal pressures, such as winter. The local authority, in partnership with the ICB, used investment to support safe management of care and support. For example, extra funding was used to support block bed capacity in residential services.

Senior leaders told us they managed safety in the care system by ensuring that all local authority staff were properly supported and equipped with the tools they needed to safely manage care. Support was provided through supervisions and learning and development opportunities, such as a Multi-Agency Solutions Panel (MASP). The MASP provided multi-agency support to staff in managing high levels of risk and complexity. Advocacy services were accessed by staff where required, but assignment of advocates was not always timely.

The local authority understood their processes for the safe movement of people between services. Staff spoke about cohesive partnerships within the local authority which supported safe, secure, and timely sharing of information to enable people to move safely between services. The move to the localities model also supported a more integrated approach across teams. Staff told us teams could work more closely together to support people and mitigate risk, such as supporting people to access urgent OT assessments and Care Act assessments.

Safety during transitions

The local authority was developing its approach to support people with transitions. There were some inconsistencies with how care and support was planned and organised with people, together with partners and communities to support safe transitions.

There was mixed feedback on experiences of hospital discharge from people and partners. Although reablement processes were performing well, partners told us the local authority could improve communication and timeliness of hospital discharges. This included people detained under the Mental Health Act 2005 who required Care Act assessments to support their discharge.

Care providers told us there had been recent improvements to hospital discharge but there had been some examples of people being discharged without appropriate support or provisions in place, with a care provider telling us they had to mitigate this risk. Some partners felt communication concerns and delays to discharge were due to a high workload and a lack of availability of local authority workforce.

The hospital discharge team told us they were now at full staffing capacity but recognised there could be delays to hospital discharges. They told us there were sometimes disagreements on the level of support required for people on discharge between staff and health partners. The team told us there was a pilot project underway to improve multi-agency discharge planning and processes to support strength-based practice.

There were clear, person-centred pathways and protocols to help prevent risk to people's continuity of care. The hospital discharge team told us their Home First and early-intervention approach supported safe transition for people from hospital to home. For example, a staff team told us a deep-clean of a person's home was organised in advance of their hospital discharge to minimise delays.

A SAR thematic analysis in September 2024 identified there was scope to improve hospital discharge processes, including discharge planning for people with complex needs and multi-agency working. The analysis recommended the Haringey Safeguarding Adults Board (HSAB) audited the effectiveness of practices supporting people leaving hospital where they had complex needs. The hospital discharge team told us due to now having a fully staffed teams, social workers could spend more time and focus on people with complex needs awaiting discharge from hospital.

Senior leaders told us there was ongoing improvement to discharge pathways, including an increase in discharging people home rather than to care settings. They told us following a move to multi-disciplinary working, communication and timeliness of decision making around discharge had improved. This supported the local authority to move towards meeting discharge targets.

Leaders, staff, and people identified safe, effective transitions from Children's to Adult services was an area for development. A new cross-directorate and multi-agency Integrated Transition Service had been in development since April 2023. The service aimed to build on Haringey's Preparation for Adulthood Action Plan (2022-2024) and drew on learning from a recent external regulator's report to improve support for vulnerable young people (14-25) transitions to adulthood. Staff told us the new strengths-based approach, which was in a pilot stage, aimed to engage young people earlier. This would allow sufficient planning time to prepare people for adulthood, employment and potential housing options.

The local authority understood the importance of maximising people's independence whilst mitigating risks. For instance, we heard young people's records were consistently updated on digital systems to ensure care continuity and safe transition to Adult services.

Pathways for identifying, assessing, and allocating complex and non-complex cases for people moving between Children and Adult services were well-understood by the local authority. Partnership working improved outcomes for young people who would not otherwise have achieved these results. Additionally, staff were aware young people undergoing this transition often had dual needs or diagnoses such as learning disability or mental health needs and worked with them and their families to provide holistic support. For example, a young person was supported to move to Adult services whilst remaining with the same provider service; this service received training from the local authority to enable them to continue to support the person as they reached adulthood.

People's and carers' experiences of transitions between Children's and Adult services were mixed. An unpaid carer told us they felt well-informed throughout their child's transition to Adult services and had a clear sight of next steps. Conversely, some young people experienced lengthy waits and struggled to access resources. Another person's relative also told us they had to chase the transitions team for the outcomes of the young person's assessment.

A carer's coproduction group facilitated by the local authority said there was work being done to improve transitions between children's and adult's services, but this was in its infancy.

Systems and processes to support people moving out-of-borough were in place. People's safety and wellbeing was supported when people transitioned to a new local authority area. The local authority funded ongoing care for 6 weeks once a person had moved to another area. The local authority ensured the receiving local authority were informed of any moves. The local authority also funded incoming people's care and support indefinitely where there were disputes over funding with other authorities until an outcome was reached.

Contingency planning

The local authority undertook contingency planning to ensure preparedness for possible interruptions in the provision of care and support. Some processes of contingency planning required development.

The local authority had clear processes to respond to interruptions to people's care and support such as in the event of provider failure, unplanned events, emergencies and cross-border service interruptions. This involved pre-set arrangements with local providers and agencies, as well as other local authority partners, to ensure services could be rapidly stood up and to secure care continuity if the need arose. Similarly, systems were in place to provide immediate care to keep people safe out of hours.

Quality assurance processes were in place to help monitor provider effectiveness and any concerns were discussed in a multi-disciplinary forum. There was a clear process to inform all relevant internal and external parties of business failure (including other local authorities using the provider) to minimise risk to those receiving care and support, and the circumstances that would lead the suspension or decommissioning of a service. Learning was fed back into the commissioning cycle, including feedback from people who used the service and their families.

Frontline staff told us proactive contingency planning was an integral part of their work. For instance, they worked closely with emergency services as part of their contingency planning to keep highly vulnerable people safe. An Emergency Duty team worked across Children's and Adult services to support care continuity 'out-of-hours', with daily handovers to the day team. Staff said they involved families to support contingency planning for those with learning disabilities in the first instance; thereafter, they would engage day services and homecare providers to mitigate risks.

We were told contingency planning for unpaid carers was important to the local authority. However, details around how they planned with carers to minimise risk when they could not fulfil their caring duties were vague. Additionally, some carers told us they did not feel the local authority had considered their future caring responsibility. A carer told us they were worried about how they will manage their caring role in the future, and another told us that future plans and respite care were not discussed as part of their carers assessment. However, some carers felt that plans for care and support were clearly explained to them and their wishes for the future were considered in their assessments.
