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 journeys; risks were identified and managed proactively; the effectiveness of these processes in keeping people safe was routinely monitored.

Leaders and staff recognised Middlesbrough was a high-risk area with crime, deprivation and exploitation being key factors in their ability to keep people safe. Waiting lists were monitored and triaged across all teams with management oversight to ensure people with the highest need or at most risk were prioritised. Referrals were initially screened across all teams and immediate action was taken as necessary to mitigate or reduce risks until longer-term support was put in place. There was a comprehensive process used out of hours to ensure people received the same level of service and protection from harm outside of normal working hours.

Staff in social work teams were trained and able to put basic equipment in people's homes to ensure safety, with equipment being delivered the same or next day in some cases. The local authority used an electronic dashboard system to monitor risk. Team managers reviewed these weekly and sometimes cases were escalated to the senior leadership for immediate input.

Monthly audits took place to notice any issues quickly and the principal social worker was able to pick out key themes from those audits to share with senior leaders. Actions were then progressed. For example, approval of additional agency workers to manage waiting list backlogs or moving staff between teams to distribute the support to those teams with higher waiting times.

The local authority's close working relationship with public health and relations with the ICB and other neighbouring local authorities in the South Tees region enabled learning and drove improvement. Staff learning forums and mini-briefing sessions were held to promote reflective practice, share best practice and learning from incidents or complaints to improve the effectiveness of processes to keep people safe.

Information sharing protocols supported safe, secure, and timely sharing of personal information in ways that protected people's rights and privacy. Staff told us they were able to exchange data with public health where this was needed to protect people from harm or support a positive experience in their care journey. However, they would not share anything unnecessarily or outside of the general data protection regulation (GDPR) guidelines.

Staff from teams such as commissioning and safeguarding attended routine information sharing meetings attended by partner organisations such as CQC, police and ICB staff. Information of concern was shared appropriately between organisations to further protect people from harm and agree actions which supported positive outcomes for people. For example, suspensions of care providers were communicated without delay to social work staff which helped promote safety within their systems. Police were able to handover information daily about anyone known to social work staff who may have come to their attention. Staff could then take action to contact the person or implement safety plans to reduce risks and support those people further.

Safety during transitions

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

There was a process in place which detailed a young person's pathway to transition into adult services. Ordinarily referrals were made to adult social care by the social worker when the young person was 17. There was a list of early referral triggers for young people who were 16. Transition cases were presented at a transition meeting which was held monthly. The purpose of the transition forum was to consider the role for adult social care and the stage at which the adult social worker should become involved and determine which adult team was the most appropriate to meet the needs of the young person.

There was a dedicated link worker in place who liaised between children and adult services, which supported the person transitioning and ensured the assessment was completed before they turned 18. Staff told us they did not leave a gap in the care the person had been receiving, and they continued working with the young person, through assessment, care planning and funding. Staff said their work with individual young people was long-term and they were part of the education health care planning, school meetings, seeking independent living housing through working closely with the young people's families and advocacy services where required. Whilst there was a robust policy and process in place and staff gave us positive feedback, the individual people we spoke with did not always have such a positive experience.

Integrated pathways were clear and streamlined for young people with learning disabilities and young people who required support with mental health. The safeguarding transition pathway was person-centred, and strength based. There was no separate transitions team, which staff reported as positive because, for example, people with a diagnosed learning disability remained open to the same allocated worker until the person was settled. This structure required fewer handovers where people and unpaid carers did not have to repeat their stories.

The local authority had specially trained staff who worked with people who were vulnerable, exploited, missing, or trafficked. They supported staff with safeguarding advice which determined the best course of action to take when they supported young people. When a person reached 18, staff explained they coordinated any ongoing safeguarding enquiries with the adults safeguarding teams. This demonstrated the local authority's approach in supporting the safety of young people during their transition journey.

Leaders and staff demonstrated recognition of children approaching the use of adult social care services in coming years who had experienced generational issues, or experienced trauma or had disabilities which had not been diagnosed or addressed. Staff were passionate about this area of work developing for the future and actions were already in place to support staff development in this area, such as trauma informed training.

Staff told us of positive outcomes including two young siblings with Autism and learning disabilities who were supported through leaving school and transitioned from living at home with parents to moving into their own accommodation with 24hr support. There was person-centred transition planning, promotion of independence and involving and listening to their parents' wishes. However, some people we spoke with said meetings to support people transitioning between services did not always take place in a timely manner. This meant people did not always have information or options available to support them in making decisions.

The hospital discharge process took place through the transfer of care hubs which were made up of discharge facilitators, social workers and occupational therapists who managed the process through working together with partners in an integrated team. Daily multi-disciplinary meetings took place which supported the 'home first' ethos and to approve requests for services.

The local authority commissioned a provider to manage the 'Discharge to Assess' service. They were available every day from 7am to 10pm to provide care packages to people who were waiting for a social work assessment. Staff told us there was no waiting list for this service. People could be transferred home or to a residential setting until the longer-term services could be put in place without delay. Where people required a more thorough NHS continuing healthcare assessment, the discharge to assess service allowed people who were fit to be discharged from hospital to go home whilst they waited.

Consideration was given to protecting the safety and well-being of people who were using services which were located away from their local area, and when people moved from one local authority area to another. For example, the compatibility of the needs of other people already living at the service. Any increased risks would be assessed to determine the suitability of the placement.

Social work staff placing a person outside of the area would only do this with the consent of the person or a person acting legally on their behalf. The main reason for out of area placements were due to a person or family's choice. Social workers visited the service and checked information about it such as CQC reports. Middlesbrough local authority remained responsible for carrying out any reviews (unless otherwise agreed), and ensured the service remained suitable, safe and were meeting any agreed objectives and positive outcomes.

Contingency planning

The local authority undertook contingency planning to ensure preparedness for interruptions in the provision of care and support. The local authority knew how it would respond to different scenarios; plans and information sharing arrangements were set up in advance with partner agencies and neighbouring authorities to minimise the risks to people's safety and wellbeing. Funding decisions or disputes with other agencies did not lead to delays in the provision of care and support.

Provider failure may be caused by several factors including deregistration by regulators, termination of contracts, loss of premises of closure due to financial pressures. The local authority told us any alternative provision would be dependent on people's needs, and they aimed to provide a service as similar as possible to the previous one.

In the event of a failure, the local authority would arrange a meeting of their 'steering group' at the earliest opportunity to agree an action plan and invoke their operational procedure. The local authority's 'Provider Failure Guidance' dated April 2024, contained a manager's checklist to ensure the process was followed correctly and promptly. It included ensuring key contacts were notified such as other local authorities, the ICB or CQC. The local authority assumed responsibility for part-funded or fully funded places for people whose places were commissioned or funded by them. They also assumed responsibility for supporting self-funded people to find alternative provision. The local authority took responsibility for coordinating and ensuring the immediate welfare of people funded by other local authorities, however longer-term plans remained with the placing authorities.

Leaders shared a positive example of their provider failure contingency plan. When they received notification that a local care home was going to close, they implemented the provider failure protocol quickly. They provided comprehensive assessments and engaged with people, families, and the care home provider to discuss alternative options. Within 3 weeks all 25 residents were transferred to similar services within the local area as they had sufficient local capacity. Whilst an upsetting experience for people and families the outcome was regarded as positive, in that actions were swift, communication channels were open and as a result everyone concerned suffered as little distress as possible given the circumstances.
