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

Safety was a priority for everyone. 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. The views of people who used services, partners and staff were listened to and considered. For example, the local authority had recently introduced a triage model for receiving safeguarding concerns and we heard from staff and partners how this had improved understanding and consistency around safeguarding. There had also been recent improvements to the use of data to understand risk. Staff and leaders told us the new IT system gave improved oversight of safety and risk around waiting lists, which had also contributed to their reduction.

The local authority's integrated strategy had identified priorities that would respond to key risks across the partnership, such as developing a strong social care workforce or ensuring smooth hospital discharge pathways. The integrated strategy drew upon data from the Joint Strategic Needs Assessment (JSNA) and aligned with the health and wellbeing board strategy . Shared priorities included plans to improve multi-agency learning opportunities and to develop a shared data set which identified themes and trends. There was a focus on prevention and ongoing work with statutory and non-statutory partners to ensure systems were robust and that they represented the people who were involved in safeguarding. This showed the local authority had an awareness of risk and knew who its key partners were to collaborate with.

Policies and processes about safety were aligned with other partners involved in people's care journey. This enabled shared learning and drove improvement. For example, the Partnership Integrated Triage Stop (PIT Stop) was set up in response to risks around people not finding the right pathways. We heard how PIT Stop had led to closer partnership working between the local authority and police, housing and health partners to keep people safe by ensuring referrals were picked up by the right agency. We also heard about multiple examples of funding being allocated to improve prevention services, in line with the strategic priorities, to reduce risks. People and partners had been involved in the development of this work through co-production which had ensured information about safety and risk was holistically captured.

Information sharing protocols supported safe, secure and timely sharing of personal information in ways that protected people's rights and privacy. We heard about information sharing in areas such as safeguarding or commissioning, so that partners could respond to risks to people in a joined-up way or address any issues or concerns in the provider market. Staff who worked alongside health colleagues in functions such as hospital discharge or mental health said they had regular opportunities to share information and could easily access timely information about people's needs or safety. We heard how staff had recently gained access to health colleagues' systems which they told us helped them have a full understanding of people's needs and risks.

Safety during transitions

Care and support were planned and organised with people, together with partners and communities 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.

The local authority had a defined pathway for young people who were transitioning to adulthood. There was a dedicated team who supported young people, and they started work with young people from the age of 14, to ready them for moving to adult's services when they were 18. There was a pathway from Children's services and a pathway for young people who may not have previously received support from Children's teams.

An unpaid carer told us transition had been challenging because they had found it hard to access information and found it hard to find somebody to talk to. There had also been an inspection by CQC and Ofsted of the Special Educational Needs Department (SEND) in May 2023 that had found some delay in families receiving information about transition. In 2021 the local authority introduced a new model for transition which was renewed and refreshed in 2023 in response to the issues identified.

Staff described good social work practice at transition, in which they often dealt with family dynamics and took a whole family approach to assessment. Staff said there was support throughout the pathway to adulthood, including links with education and the ability to involve the GATES employment support service where a young person may be looking to seek employment from the age of 18. There was a defined process of Care Act assessment to establish eligibility, with services in place ready to support any young people without eligible need.

The local authority had good links with partners and worked with local special education schools to involve key partners in preparing young people for adulthood. Headteachers from special education schools had visited the supported housing schemes young people could potentially move to, so they were familiar with the options for young people when they left their schools. Staff said they were able to get to know families early and build relationships with them over the time they worked with the young person and their family, which was usually from the age of 14 and sometimes continued until 25 years old.

There were defined pathways for hospital discharge that people could follow depending on their needs. Pathways included access to intermediate care such as reablement or residential rehabilitation or pathways where people required longer term options. Staff spoke positively about the 'discharge to assess' model and how it had been enhanced by increased capacity in homecare and reablement. The local authority and partners used a trusted assessor model, where trained health colleagues could carry out assessments to enable a quick discharge into intermediate care and any ongoing care needs were picked up by local authority staff. Staff said these assessments were effective and enabled people to achieve goals to develop independence. The records we reviewed where people had been discharged from hospital supported this.

Local authority data showed discharges happened smoothly with very few delays because of lack of service provision on these pathways and people's needs were reviewed to check if they had longer term care needs. The local authority also had a PRIME team, who proactively contacted people discharged from hospital and provided support where there was any unmet need. The team also sometimes supported people in crisis within the community to avoid hospital admission. Staff described multiple examples of this team becoming involved and supporting people while longer-term care was arranged.

Hospital discharge staff worked with health colleagues to enable a smooth transition from hospital. Staff told us about joint work with health colleagues like physiotherapists or nurses to ensure complex discharges were planned. Staff had access to health systems and described constructive and helpful teamwork, including in decisions around funding. There were clear links with the locality teams where people would be supported and reviewed if they had longer term care needs.

For people discharged from the mental health hospital, there were clearly defined pathways and local authority staff worked closely with their health partners to ensure people were discharged safely and had their needs met. There was not a formal agreement in place to integrate local authority and health in mental health teams, but there was strong partnership working that ensure people's needs were met safely. Staff told us about multiple examples of partnership working to commission innovatively to meet complex need and enable people to move to more independent living. Staff described using strengths-based practice alongside health interventions to deliver care in a joined-up way.

There was good communication with health colleagues to support smooth and safe mental health pathways. Local authority and health staff often learned from each other to improve pathways. For example, staff described how they had invited commissioning colleagues to multi-disciplinary team (MDT) discharge meetings to improve health colleagues understanding of commissioning. This had helped ensure bespoke commissioning models were developed based on all the available information about the person.

Specific 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. We heard how staff remained involved and there were frequent reviews and checks. For services commissioned outside the borough, the local authority monitored these and liaised with the host local authority if there were any concerns.

Contingency planning

The local authority undertook contingency planning to ensure preparedness for possible 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.

Contingency planning included protocols for extreme weather or interruptions to service for providers or the local authority. There were plans for staff or management cover, including emergency rotas and evacuation scenarios.

There were plans to support providers to prevent cessation of service and protocols if providers were unable to continue operating. Staff described close monitoring and support mechanisms, including the use of partner agencies, to support providers where provider failure became a risk.
