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 had sought feedback from partners via a survey in 2023 and partners had ‘agreed’ or ‘strongly agreed’ the local authority worked with them to manage and maintain safe systems and safe transitions between services. People also agreed transitions between services were prepared for in advance. We saw in case notes evidence of systems being put in place to minimise risk for people.

Partners said the local authority supported people well in housing settings. For example, we heard the local authority provided a digital monitoring system as a service with no charge for up to six weeks following hospital discharge. Staff working with the equipment had access to the local authority’s electronic record system, which meant people's support and care was safely managed whilst transferring between settings.

We heard from staff about protocols working well, for the transfer of people and their care between teams, and arrangements for hospital discharge and admission avoidance was a strength in the local authority. Access to records between health and social work colleagues, however, relied on staff proactively contacting workers and could not be accessed via a shared record.

Access to the out of hours services was gained by telephone in the contact centre and the out of hours team triaged and prioritised each call ensuring the person was safe until the next working day. For example, when a person’s carer had become ill, respite care was put in place through the out of hours arrangements.

Clear escalation processes were in place, including around ‘Right Care Right Person’ (RCRP) (a model developed by the Police that ensures the right person responds to concerns about a person’s health and welfare in an emergency). Staff told us about a person who collected their prescription each day and hadn't, unusually, for 10 days. Two workers attended the property and after following procedures and the RCRP methodology, were advised they were able to enter the property without the police in attendance, to check on the person. Cases were reviewed and the safety of them was monitored. Processes were aligned with other partners involved in people's care and this enabled shared learning and drove improvement. Learning on this case followed a management review. Staff and partners said the out-of-hours and emergency duty team arrangements worked well, as a commissioned service across the 5 local authorities. Handover information was provided both by telephone and electronically. Staff said housing staff communicated effectively with the out of hours service and alerted them if they were aware of a person who was likely to present out of hours.

Safety during transitions

There was a ‘Continuity of Care Practice Guidance’ document dated June 2024 which set out what was required when a person moved from their ordinary residence to ensure continuity of care and support. It also provided clear guidance on disputes and complaints.

There was a clear and easy-to-follow flow chart on the process for a child transitioning to adult services. The ‘Children's Final Sufficiency and Commissioning Strategy’ 2024, also demonstrated policies and guidance around safe transitions in the local authority and specific consideration was given to protecting the safety and well-being of people who were located away from their local area and when people moved from one local authority to another. The discharge to assess pathway guidance aligned with statutory hospital discharge and community support guidance it set out for discharge pathways.

People's feedback around transitions was mixed with most people giving positive feedback. We heard examples of limited information about people's needs being provided to new settings with limited contact from staff ahead of the move. However, we heard positive examples of social workers supporting people with application forms for housing and benefits, and cases where the transition from home to supported living went very well. We saw many examples of people moving from hospital settings into the community with the RIACT team utilising 'discharge to assess' beds, physiotherapy and occupational therapy support effectively. It was clear the multidisciplinary team approach led to consistency about goals and activities. People shared a sense of fear and concern, when considering the future lives of a cared-for young person, around the differences in approach and availability of support of children's and adult services. Some people expressed a wish there was further information and engagement from adult services in order to ease their anxieties in advance of a child's transition.

Partners said discharges were managed efficiently and there were low levels of delayed discharges or people in hospital who did not need to be there. Staff said there had been a lot of work done around transitional safeguarding and they were now looking at preventative work and how they could support people's safety once they transfer, they also spoke about a 'think family' approach to ensure safety. Staff said care placement brokerage worked well in hospital discharge and gave an example of when a person who spoke Urdu and Punjabi was discharged home. Home care workers who spoke the same languages were sourced which worked well. Another example of a person from a Gypsy, Roma and Traveller ethnicity was supported to find a care home which had workers from the same background, and the placement had gone very well.

Partners gave very positive feedback about transitions between services, and we heard social workers ensured planned moves were in a person's best interest and worked with advocates where necessary. Face to face reviews took place within six weeks of a new placement and partners said these reviews worked well. They said the local authority did not hurry transitions between placements, enabling overnight stays and trials, and said the local authority was person-centred when organising transitions between services.

Contingency planning

The local authority had guidance in place in the event of home care providers initiating contingency plans (when providers were closing or when there were unplanned disruptions to care provision) and the process set out how people would continue to receive care. There was an 'approved mental health services' business continuity plan which would activate in the event of a disruption in service. We saw similar business continuity plans for the adult social care mental health team, the ACT team, occupational therapy, commissioning contracts and brokerage teams, RIACT, in-house supported living, day opportunities, short breaks and safeguarding adults and DoLS teams. People said they were confident the local authority would provide support if the care was interrupted for any reason.
