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 risks to people across their care journeys.

Systems were in place to access referral pathways and safeguarding teams out of hours. For example, the Emergency Duty Team accessed referral systems and had support from Careline Personal Alarm Service and on-call managers. They were able to contact care providers out of hours when people were referred.

Information sharing protocols supported safe, secure and timely sharing of personal information in ways that protected people's rights and privacy. For example, a process was in place to handover information to day teams including Access Harrow to support continuity. When people were discharged from hospital, their information was shared securely with partners where required and staff confirmed they understood how to maintain confidentiality for people using services.

Safety during transitions

Care and support were planned and organised with people and the people who were important to them, to improve their safety across their care journeys and ensure continuity in care. This included referrals, admissions and discharge, and where people were moving between services.

The increase in access points as part of the restructure of the neighbourhood teams had made pathways such as hospital discharge smoother, as they now had a dedicated hospital discharge team, to work across the borough.

Most providers told us they felt supported by the neighbourhood teams, who were responsive and pro-active. However, there were mixed experiences regarding responses where cases were transferred from the hospital social working team in relation to communication.

The Hospital Discharge Team assessed people's needs when they were medically fit for discharge to determine whether they required any ongoing support. They told us they rarely had any problems in arranging the support people needed in a timely manner.

NHS health partners attributed missed NHS targets on 30-day discharges following admission to hospital to slow local authority discharge processes for people with mental health needs.

Occupational therapy and sensory service processes and pathways were clear, and aimed to deliver timely, tailored support to people to maintain their independence. This was facilitated through a collaborative approach involving care managers, occupational therapists, sensory workers and stroke co-ordinators alongside a wide range of additional resources.

The local authority told us they provided personalised support to meet the needs of young people to grow into independent adults. We were given examples of supporting young people into employment, to move out of home and of strong family work to help parents see the potential of their loved ones. The local authority had a clear process for children transitioning into adulthood which commence with planning at the age of 16 years old or earlier if the young person had disabilities.

Young people with learning disabilities had their care plan and ongoing care package in place before transitioning to the adult learning disability team at the age of 25 years old. The children with disabilities service merged with the transitions team in 2016. This provided a consistent response to children and young people when moving across services. Whilst the transition policy was in draft, the local authority was able to provide a written document which described the end-to-end process of children transitioning into adulthood.

When people moved from one local authority area to another, the local authority took steps to ensure there was no gap in service.

Contingency planning

The local authority had contingency plans in place to ensure preparedness for possible interruptions in the provision of care and support. The aim and purpose of the Major Incident Plan was to provide staff with the information required to manage the effects of a major emergency or incident occurring in the borough. The plan outlined the framework for managing and coordinating that response.

There had not been an unplanned emergency provider failure in the last 12 months and there was no procedure specifically for unplanned provider failure. The local authority had a series of mitigations to avoid failure and two relevant procedures if a provider was closing or causing concerns, that would be adopted. Staff gave two examples of where they worked with providers to avoid service disruption in Short Breaks and Extra Care. The local authority acknowledged it should review existing procedures and develop an unplanned provider failure procedure.
