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

People and their carers had access to local authority support 24 hours a day and 365 days a year. Processes were in place to keep people safe including formal escalation and handover processes when people moved between services. There were on call processes that meant people in need could access emergency care or housing support out of usual working hours.

During the previous year the local authority had used staff feedback and audits to identify there were unclear boundaries and delays in transfers across some internal teams. As a result, the local authority had taken actions to improve internal pathways. They had reviewed organisational structure documents and handover guidance to provide greater clarity. Staff told us that where communication was once poor, they were now confident and trusted the handover processes which had improved communication with people using services and reduced delays.

Information sharing and processes to support safety were effective. For example, staff told us that processes supported co-working and a cohesive approach between the advice and contact team and the emergency duty team. Staff accessed the same digital systems and people contacted the same telephone numbers day or night. There was the need for some staff to access multiple systems such as health or provider records, and we were told this was provided. Staff told us where the digital record systems didn't link up, good professional relationships made up for this to support personal information to be shared in ways that protected people's rights and privacy.

Safety during transitions

Transition is a time when the differences and gaps between services and support can be particularly evident and problematic. A joined-up approach across relevant partners and agencies is critical, to achieve the best outcomes for young people, adults, unpaid carers and their family and reduce risks of any loss of continuity in care and support. The local authority had processes to support pathways when people moved between services and agencies that included children into adulthood, hospital discharge, moving to another local authority, transferring between services and for people who could no longer fund their own care. We heard positive feedback from staff about support from residential care into supported living, improvement and co-production working with prisons, and out of area quality and commissioning support to enhance people's safety.

There was mixed feedback from people, staff and partners about the arrangements for safe transitions from child to adult services in Wiltshire. The 'Moving On Service' was a new and dedicated team to support young adults between the ages of 18 and 25 years old. An allocated worker model mirrored what was offered in children's services; link workers could support people from age 15 to 16 years old to begin transition preparation. Referrals came through the advice and contact team and children's services teams (apart from referrals for young people with a disability which followed a different pathway). The service bridged the gap between children's and adult services with clear processes for young people already known to services, children in care and young people who were not already known to services and did not already receive support from the local authority.

However, the local authority was aware there was still room for improvement in this area and acknowledged partners, young people, and their carers experiences, some of which had described transitions to us as a 'cliff edge' and 'falling through gaps'. There was ongoing project and improvement work to develop ways to identify these young people and their needs such as the work around transitional safeguarding, neurodevelopmental pathway, child and adolescent mental health services as well as deep dive audits. Senior leaders and partners told us the Parent Carer Council influenced projects and services including through strategy which had been fully coproduced with young people and families. We heard from carers and partners examples where concerns had been raised and quickly addressed as a priority. For example, some people who were due to transition from college education, were told they could not refer until 6 months before their education ended when they contacted the advice and contact team. This was raised by unpaid carers and partners as a contradiction to communication in college presentations which encouraged referrals as early as possible. As a result, this barrier was raised with managers and a clear message agreed with the advice and contact service.

Signposting, internal referrals for housing support and the promotion of the local authority's in-house services, such as day services, were in place to support successful transitions. For example, the local authority supported young people and their families to view services; offered easy-read information about service; cross-working and collaboration with the school's cafe and taster days. Staff told us working with young adults was not just a job but a passion, they took pride in knowing people well and had a strong want to 'do the right thing'.

The Care Act places a duty on local authorities and the NHS to work together to ensure the safe and timely hospital discharge of people with care and support needs. The NHS and local authorities should use the best evidence available, develop and apply local processes that ensure all people with care and support needs to achieve appropriate, timely and safe hospital discharge. Referrals to arrange physical health hospital discharges went to one of three Transfer of Care Hubs (ToCH) in the area. A ToCH is a health and social care coordinating centre linking all relevant services to aid discharge and recovery decisions, and the local authority is a key partner in effective delivery. If a person was transferring or returning to a care provider at the point of discharge, there were processes to support this. People using services and their carers gave positive feedback about physical health hospital discharges in Wiltshire.

The Trusted Assessor (TA) service was a service for people who are being discharged from hospital to a care service run by providers (in the Wiltshire Care Partnership). The Trusted Assessor service undertook assessment of the person's care needs on behalf of another care provider. Any care provider could access the service, and it covered the whole of Wiltshire including neighbouring counties where needed. Partners told us the service is trusted by local care providers and provided full assessment for people being transferred from hospital. Senior leaders told us this service helped to move people through the system smoothly and quickly. Between July 2023 to December 2023 the service completed 224 assessments for care providers.

When people moved from one service or local authority area to another there was access to seven-day integrated brokerage supporting adults and children across Wiltshire. They provided a same day response rate and no waiting list to start sourcing support. The brokerage service actively took part in daily multidisciplinary meetings to ensure any barriers to discharge could be resolved quickly. The local authority said there were an average of 7000 referrals per year to the brokerage service to support people. There was an escalation process to escalate a change in urgency for a package of care or a change in need. This supported people's experiences of hospital discharge and minimised their length of hospital stay.

Contingency planning

The local authority undertook contingency planning to ensure preparedness for possible interruptions of its delivery of duties under the Care Act, including interruptions in the provision of care and support. There were policies and processes to ensure the needs of people receiving care and support services continued to be met in untoward events such as, imminent business failure of a regulated care provider, immediate deregistration and closure of a regulated care provider by the CQC, a major and immediate unplanned business interruption (for example a significant fire or flood), and where the care providers' own business continuity plan was unable or had failed to reduce the impact of risks on the people they supported. For example, staff described the actions taken when a care home was closing for financial reasons and had an inadequate CQC rating. The local authority organised a multidisciplinary group of professionals to manage the risks and understand people's needs, whether the local authority funded them or not. A responsive specialist public health protection nurse role had been created which supported business disruption events relating to quality, transfers of care and infection prevention and control concerns.

Specific consideration in relation to safeguarding, quality, contracts and commissioning was given to protecting the safety and well-being of people who were using services which were located away from their local area. There was sharing of information across local authorities about out of county placements. The local authority held an out of county tracker to support oversight. In the event of the local authority being notified by another local authority of a regulated provider business failure in their area (and when people who ordinarily reside in Wiltshire were supported by that provider), then appropriate operational support was allocated to help people to move to alternative services, commissioning and brokerage were also involved in this process to minimise the risks to people's safety and wellbeing.

Activating emergency response groups, use of market oversight meetings, and analysis of data to monitor risks to provider business continuity were used. There was a good awareness of how data informed actions to support and reduced risks to people using services. For example, at a market oversight meeting it was recognised through data analysis, a care home had a theme of safeguarding incidents. This triggered an existing link worker to focus on this area during their ongoing visits to the care home. This allowed the local authority to prepare for possible disruptions and provide targeted support to care providers.

Staff and partners told us about work carried out in relation to international recruitment by care providers, and risks in Wiltshire of modern slavery with unethical international recruitment practices highlighted by the police. There had been good partnership working in this area. As a result, the local authority used an 'International Recruitment Risk Analysis tool' to identify the level of risk presented by care providers who used sponsorship licences (for example, risks created by licence revocation) to decide the level of monitoring or action needed. The local authority knew the number and ratio of staff operating under the certificate of sponsorship scheme within care providers in Wiltshire. This was balanced with the number and needs of the people the provider supported. The tool supported decision making around what action needed to be taken (for example when the local authority needed to move people to another provider if there were risks in the current one). This included people that self-funded their own care to ensure safety was a priority.

Funding decisions or disputes did not lead to delays in the provision of care and support. Depletion of a person’s finances could lead to a move between services of their choice. However, there were processes in place should a person not be able to continue paying or contributing towards their care and support to ensure there was continuity of support.