Safe systems, pathways and transitions

Indicative score:

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.”

“I feel safe and am supported to understand and manage any risks.”

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

Staff, people and partners told us improvements were needed in the transitions of young people to adult services. Transitions is when a young person under 18 who has received support from Children's and Young People's services, or has additional needs, nears adulthood. For example, one person's family member told us that they had driven the transitions process and there was no handover between the children's and adult's services, which meant it took more time to establish these relationships.

In the past, transitions work had been shared across specialist and locality teams, but this had led to some inconsistencies in working practices. Staff explained there were several challenges currently with transitions, including a gap in the current criteria, for example if the young person was not formally diagnosed with a learning disability or had physical difficulties. Transition services had not always commenced early enough in the past, which had an impact on recognising where there were gaps in skills, or where these needed to be developed, to help young people to move into adulthood. Supporting with housing could be challenging too, especially if people's needs were high as there was a lack of provision available.

Healthwatch published a report in July 2022 on feedback about the experiences of young people's transitions to adult health and care services in Suffolk. The responses they received were mostly negative. Themes included a lack of information, lack of effective communication and no cohesion between the agencies involved. Some people said they received little or no support. Insufficient information was available about preparation and the process, including financial implications. Two people experienced difficulties finding appropriate support for specific health needs. People described a lack of cohesive working between children's and adult's services.

Plans were underway to address some of these issues. Transitions staff had been moved across into the adult's teams, additional staff were going to be supporting the transitions work and a new manager was being recruited. Although this work was planned, staff told us they were not clear of timescales of plans currently.

One senior member of staff told us this area was a priority for improvement for them and longer-term aspirations were that all young people moving into adult services would have a consistent service with a seamless transition overseen by a single team of subject matter experts, managed within Adult Care Services.

Feedback from staff was that improvements were required in relation to discharge from hospital in some areas, including cross-county. For example, there was a lack of integration and close working with some hospital discharge teams and there could be a disparity at times between care assessed in hospital and the care people required. People were being fully assessed once home with a package of care. By contrast in other areas, staff felt there was more integrated working, sharing of information and working between the hospital and communities, with a real focus on 'admission avoidance' where people were really at the centre of all decisions.

There was clear guidance for staff in the event of a care provider failure (such as an urgent care home closure) in relation to moving people from a service. One partner told us if a care provider was failing, the local authority provider support team were 'very quick' in ensuring that people's needs were re-assessed as part of planning, for example if they had to move to another service. There was also clear guidance for staff when placing people out of county in relation to managing risks and ensuring good quality care was provided.

Staff and partners identified some challenges when working in partnership with health, including the use of different IT systems for recording information and sharing data. The 'Health Information Exchange' was a shared digital platform under development so that health and local authority staff could see records on their systems. This was hoped to save time by not duplicating resources and enabling staff to access the full information about people when making decisions. Health and social care workers currently had some shared access to each other's systems, but this was often on a limited basis, which meant people may have to provide their details on several occasions to the same teams.