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 transitions process map, demonstrated coordinated support across agencies, including when people moved between services. Derbyshire Safeguarding Adults Board (DSAB) provided learning resources, after collating data and other findings, to staff. Staff said the trauma-informed relationship-based practice model, used by the leaving-care team, was effectively used to support people transitioning into adult services. This model was used to develop safe and supportive relationships, between staff and young people who may have experienced developmental trauma. However, DSAB found communication needs were not always met and information was not always offered in different formats and better information sharing was noted as an action point.

Leaders said young people were identified and supported from the age of 14, with reviews every six months. Joint visits had been undertaken between the children and adults staff, to support positive transitions policy and practice. The adult transition survey results showed 61% of staff reported they were 'not very confident' around transitions processes. 87% of staff stated they required training and did not feel they were sufficiently informed about children's social care legislation. The local authority has subsequently told CQC that a transitions training offer has been developed.

There were established processes to support the hospital discharge team with safeguarding referrals. Partners said the adult social care discharge fund had been managed well and late discharges had improved against the previous year and delayed discharges had reduced.

Derbyshire Community Health Services (DCHS) and the local authority worked together to improve discharge pathways, particularly when a person had lower-level needs and included an urgent community response. The joint vision was consistently described as responsive assessment, short-term intervention and reablement, supporting people to remain at home in times of crisis and supporting timely discharge. The discharge assessment review team (DART) gained mostly positive feedback however there were some concerns raised with us from partners about the consistency of the level of support available to people leaving hospital, such as the gap between the VCSE aspect of the team's offer and those of statutory services.

Mental health discharge planning could be challenging, and there were mixed reports about access to shared records. Recently the deaf and sensory team had gained access to the shared-care record and found it very useful in their day-to-day work, giving examples of it enabling access to interpreter services when a person was in hospital. Other frontline staff reported positive use of the system and we heard it was in the process of being rolled out to more teams.

While Approved Mental Health Practitioners (AMHPs) had access to the shared care record they did not have access to the mental health trust's electronic records system, which they said would have helped them assess risk. Out of hours social workers received training on using the system which helped them to assess risk. We heard the numbers of AMHPs on shift overnight had increased from 2 to 4 following an increased need and they were co-located with the crisis teams in Chesterfield Royal and Royal Derby hospitals which supported good partnership working around safety.

Safety during transitions

We heard mixed feedback about people's experiences of transitions from Childrens to Adults services. One person told us the process had gone smoothly, where adult carers had shadowed children's carers to get to know the person, and provided a safe transition at 18, with community connections involved. Others described less continuity and a desire for more support. We heard each locality team held Childrens to Adults casework and staff capacity could be an issue in the delivery of transitions services. This led to people sometimes being assessed nearer the age of 18. We heard a clear commitment from staff to completing extended assessments, including where Childrens social workers needed to travel significant distances out of area.

The winter and spring period had been challenging for effective hospital discharge. Despite this, the use of the low-need discharge pathway (1) had experienced an improvement in its performance. We heard discharge pathways for people with greater needs (2 and 3) had been strained and sometimes overused, leading to some people being provided with higher levels of support than ideal for longer, because other services were at capacity. We heard from partners the authority paid providers for urgent increases in packages when necessary.

The local authority commissioned 'home from hospital', a VCSE service, through grants including the Better Care Fund (BCF), hospital discharge money and public health funding. It provided befriending, shopping and a handyman service. It supported admission-avoidance and was also referred into from the carers and dementia services. Hospital discharge teams in the area worked well, involving good joint working with social workers.

The Enhanced Support team worked well to prevent hospital admissions for people with learning disabilities and autistic people, and to discharge people from long stay hospitals. They also worked with some children at the aged of 14, but mainly by age 16, supporting transition to adult services. We heard the deaf and sensory team provided transitional support to children and received referrals from 14 or 15. This included transitions from the school for the deaf in Derby.

Mental health acute hospital discharges could be complicated by a shortage of supported housing services for homeless people. We heard however, of an example where a housing officer was routinely present in a mental-health hospital, to support housing on discharge. Neuro-development hubs had been implemented across Derby City and Derbyshire for children and young people who were neuro-diverse.

Community support beds were also used to support people being discharged from hospital, with daily flow meetings to look at occupancy levels and people who could be discharged. They worked with social workers and the reablement team for people to become as independent as possible and return home with a package of care, if required. There was an occupational therapist embedded in the discharge team to prevent overprescribed care on discharge, or care packages which were difficult to source, supporting safe transitions between settings.

The majority of feedback was positive from people about how their care was coordinated to support hospital discharge. The discharge process had not felt supportive enough for some patients with dementia, however, who may have required a higher level of support. We heard very positive feedback about the way short-term direct payments had been used to increase care availability on hospital discharge and following periods of reablement. Homecare packages, in place prior to admission to hospital, were held open for a person in order to support ease of discharge. Social workers, including out of hours, re-assessed needs following a hospital stay and liaised with the provider. If someone was admitted to hospital for over 72 hours their reablement intervention was also re-started on discharge.

Contingency planning

There was a ‘managing provider failure’ (and other disruptions) process document, showing how the local authority intended to maintain safe systems of care in the event of service interruption or provider failure, either in a planned way or in the event of an emergency. Leaders described a local resilience forum and an emergency planning service team, mutual-aid arrangements and emergency preparedness. We heard about community rapid response teams who stepped-in following a homecare breakdown. There was a mutual-aid arrangement in place for homecare with Staffordshire County Council and with Derby City council which had been used. There were also informal reciprocal arrangements across neighbouring local authorities around quality assurance and contracting and market arrangements.

The brokerage team supported contingency planning, direct payments and possible interruptions in the provision of care and support. The geography of Derbyshire presented challenges, as did winter weather, risking interruptions in provision. There were support contingencies in place which included the internal short-term reablement homecare team. We heard an example of care home closure where the local authority worked with the provider and sourced additional funds, to support the safe transfer of people using the service.

The out of hours social work team described working very well in crises, for example during times of flooding last year in Chesterfield. Staff volunteered to help during non-working time and service managers pre-empted demands and planned appropriately when there was knowledge in advance about disruptive events. The team gave examples of sourcing emergency respite, sourcing support following carer hospitalisation and around placement breakdowns and described good joint-working with the police. There was therefore demonstrable capacity for the local authority to respond to many unexpected and emergency situations.
