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

Proactive work around winter planning for people's needs had taken place with health partners by getting the relevant people from across services together. Every few months a team would meet to discuss each sector with a lot of the work focused on keeping people out of hospital or supporting them on discharge. Initiatives included wrap around care to keep people within their homes, night support and bridging services.

Staff teams in Brent benefited from working closely together, however identified that a better understanding of each other's processes, would improve this further. Safeguarding partners confirmed they were working closely with social care staff to improve transitional safeguarding (when young people moved to adult's services). This followed a commitment from the local authority to ensure care leavers were well supported when they reach adulthood. Senior staff explained the strategy behind the transitional safeguarding approach but that there needed to be more practice development to ensure it was understood by staff. For example, the transitions and adults teams were working jointly to discuss cases, but this needed to be improved further. An improvement plan was in place highlighting that transitions workers needed more safeguarding training as currently they did not have the experience to pick up Care Act section 42 safeguarding enquiries.

Safety during transitions

Care and support was planned and organised with people, together with partners and communities to promote safety across care journeys and continuity in care. This included referrals, admissions and discharge, and where people were moving between services. Staff in front line access teams provided a triage and visit function for new and existing people. If any immediate care needs were identified, then care packages were put in place prior to handing over to longer-term teams and they would continue to manage this for 6 weeks following contact to ensure stability.

Improvements to hospital discharge had been made by creating the post of dementia nurse to support safe transitions. Joint training had taken place with ward staff to address the quality of referrals and the use of Trusted Assessors ensured people did not need to see multiple professionals unnecessarily to be discharged.

A handyman scheme was used to support quick and safe discharges to people's homes, such as installing key safes and environmental changes. For example, one person could no longer go upstairs, so they had support to move their bed to a ground floor room to enable discharge. Another person had an infestation of bedbugs at their property and the service carried out the work needed to support the person with this.

Services to support people on discharge from hospital varied from a night watch service to a pop in service commissioned by an agency. Staff felt this was positive and helped people to settle at home. The Trusted Care Pathway, enabled a person to be collected from hospital by a commissioned care provider and set up at home with items such as groceries or medication, allowing for further assessment which helped establish the correct package of support. Eleven beds were also available across three locations as a 'step down' from hospital when people required some further support.

Following the continuation of issues with the supply of aids and equipment, staff were able to have conversations with the hospital and, if unable to source these, people would not be discharged if it was unsafe. Risk assessments were completed to identify what measures were able to support safe discharge if items were delayed.

Processes supported staff to understand hospital discharge pathways. For example, one process documented mental health hospital discharge social workers should carry out assessments for hospital discharge and work with clinical staff to assess needs jointly. Staff however told us that this did not always happen in practice, and they felt disheartened at times as people were discharged too soon. Additionally requests for reviews of people with mental health needs in long-term placements when they were due for discharge, did not always allowed for timely assessments of people's needs.

Risks were managed for young people receiving transitions assessments. For example, staff worked closely with families completing mental capacity assessments to establish if people could make decisions independently. Assessments were completed for people identified as having eligible needs and the team aimed to begin this process from age 14, however this was not consistent and often a young person would be allocated to a worker in the team when they were 17. One person and their family told us they had not been made aware of their eligibility for a Care Act transitions assessment and as a result had sought privately funded support. Senior staff told us they were working to improve this and begin engagement earlier. The local authority had co-designed a transition offer for young people and parents/ carers, which was published on their website.

Some challenges were reported in supporting young people in the transition to adults' services, as there was a discrepancy between the offer of children's to adult's services. Therefore, staff felt it was important to manage expectations as support under the Care Act was often a reduced provision offer to what the young person had experienced previously. Consequently, it was identified that if services were reduced incrementally in preparation for adulthood, this would be more effective and less impactful on the young person and their family. Some support was given for young people to develop independent living skills, however staff felt this was an area which needed to be further developed. Likewise, there were some gaps in current health offers in relation to young people with mental health, autism and ADHD (attention deficit hyperactivity disorder) needs, which limited opportunities for preventive work and the possibility of young people needing acute mental health care. Staff described how some support ceased when a young person turned 18 and the provision to support these people was limited in adulthood.

Providers were surveyed around safe transitions between services with 77% of providers giving positive responses. Feedback from one provider followed an effective and coordinated hospital discharge process. Other partners were positive about the hospital discharge teams, describing effective systems of daily discharge meetings and calls which helped the social work teams based in the hospital and promoted relationships and information sharing.

Contingency planning

Plans for the future, or unplanned situations, had not been always been discussed with carers, however, we received feedback that emergency support had been provided when an unpaid carer was no longer able to continue supporting a person. Alternative care provision had been immediately sought to ensure the person had a safe transition to alternative accommodation.

Staff teams for people with learning disabilities and autism considered emergency planning as part of people's assessments. A duty number was available for people to contact when emergencies occurred, so that alternative support could be put in place.

Processes were in place to support contingency planning. For example, an Incident Management and Business Continuity Plan detailed a response structure, responsibilities and an actions checklist for emergency planning in the event of failure or loss of service.

Engagement and monitoring arrangements enabled the local authority to get early warnings of potential service disruption or provider failure. Processes were detailed in the Provider Failure and Service Closure Plan (February 2024). There had been 4 care home closures in 2023 and 1 in 2024, where people had been supported to move to alternate accommodation safely.

The local authority had its own emergency plans for service disruption which included the loss of premises, of IT and telecommunications and staff. This plan included assessment of risk, how this should be cascaded to senior staff and responsibility for recovery of services.
