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

Senior leaders at the local authority had a clear understanding of the importance of safety and of the risks people faced across their care journey.

Safety was a priority in Bracknell Forest. Integrated health and social care teams and jointly agreed pathways made it more likely that people would be safe during times of transition between services.

Information sharing protocols supported safe, secure, and timely sharing of personal information in ways that protected people's rights and privacy. All the staff, leaders, and partners we spoke with gave assurance that information was shared safely, under appropriate governance arrangements. The local authority and local health trusts had invested together in Connected Care, a data repository which was accessible by different organisations and enhanced information sharing. The hospital patient administration system allowed local authority access to information, enabling the GP and local authority to see patient details when admitted.

Staff told us the integrated Community Mental Health teams for adults and older adults, enabled seamless transitions between services, with access to each other's systems and effective information sharing which resulted in more holistic care and support to people. This model supported prevention of hospital admission, and reduced lengths of stay when admissions were necessary. This included working closely with the Locality Access Contact Team who provided additional support and enabled a rapid response for people in crisis.

Staff spoke of strong partnerships with services both within the local authority and the community which enabled sharing of information to reduce risk and supported keeping people safe in the community. Policies and processes about safety were aligned with other partners involved in people's care journey. This enabled shared learning and drove improvement.

Safety during transitions

Care and support pathways were planned and organised with people, partners and communities to improve their safety across their care journeys and ensured continuity in care. This included most referrals, admissions, and discharges from hospital, and where people were moving between services.

There was a framework in place for the Approaching Adulthood pathway from age 14, and information was available for the public and a documented process to show how young people known to the Child and Adolescent Mental Health service (CAMHS) would transition to the Community Mental Health Team (CMHT) for adults.

Staff said they worked in partnership with children's social work teams, specialist teams for looked after children and those leaving care to enable a seamless transition between teams with quarterly meetings scheduled where information could be shared. The pathway focused on a co-ordinated assessment of their adult care needs, to ensure that services met the holistic needs of each young person. It also ensured the young person and their families had a voice and could participate fully in the assessment process. This might result in a referral to advocacy services. Staff told us they worked in a strength based, individualised way but the majority would either no longer need support or be transitioned to an adult team by the age of 18.

We were told of a young person who recently turned 18 and is now under the transition to adulthood team. Their carer requested the same social worker to support them as was supporting their sibling. This social worker already knew the whole family. The family felt this would be the most appropriate solution and the local authority agreed. This made the transition process feel easier and seamless. In contrast we also spoke with two other carers of people who had recently transitioned from children to adults' services and neither felt supported during the transition.

We also heard from one person who told us there were no referral pathways between the Special Educational Needs teams and the local authority for an autistic person with learning disabilities not known to the social care team at the local authority, who needed an assessment to identify on-going support post mainstream/specialist school settings. They experienced this as a barrier to their getting the help and support they needed.

An audit of 5 transitional cases relating to young people in a variety of circumstances, including youth justice and being a care leaver with mental health needs, was undertaken in February 2023 by the Bracknell Forest Safeguarding Board (BFSB). This found inconsistent performance against 6 principles which ensured effective, person-centred planning for a safe and smooth transition to adulthood. It found that existing systems and pathways were complicated but also that there needed to be better working together and more co-ordination of support. Staff did not consistently use processes and guidance such as Mental Capacity Act. The audit resulted in an action plan which was being overseen by the Board, under a transitional safeguarding subgroup. The January 2024 update to this plan showed that all actions but one were either on track to be delivered or completed. The one item requiring attention related to auditing and had its own ongoing action plan. The issue of legal literacy and the need for more staff training in applying the Mental Capacity Act has been identified and has been incorporated into the learning plan for the adult social care directorate.

There were 3 pathways for people for preparing to be discharged from hospital. Workers were allocated cases very quickly and information was sent using a secure email address. Discharge plans were discussed by a multi-disciplinary team to ensure clarity and consent was gained from the person.

We heard however that not everyone had a smooth transition when responsibility for funding care moved from one local authority to another, or when an individual's savings fell below the threshold for local authority funding. One person described that the local authority entered a dispute over funding with the host local authority after a person had been placed in a home out of borough, which resulted in a long wait for the person to receive financial support for the care placement when they were no longer self-funding. Another person told us, when an agreement had been made between the local authorities, a social care assessment was quickly arranged, but the person had already undergone the assessment process with the other local authority. The person was in a care placement, and therefore their needs were being met throughout, but the time taken to repeat the assessment increased frustration and personal cost.

People who were placed away from their local area were supported and kept safe through ongoing working relationships between commissioners, especially for providers who were out of Borough but not out of area. We heard of good effective communication about risks or concerns which were shared. People out of area also benefited from social work reviews in the same way as people who were in placements in Borough.

Contingency planning

The local authority had contingency plans in place and were prepared for possible interruptions in the provision of care and support. They knew how they would respond to different scenarios such as extreme weather, cyber-attacks, loss of access to local authority buildings or loss of staff. Plans and information sharing arrangements were in place with partner agencies to minimise the risks.

Bracknell Forest told us they had not used their provider failure policy and procedures during the last 12 months but had clearly set out how the service would mobilise in a failure scenario. Individual roles and responsibilities were identified. It was expected that all staff should be trained at least every 18 months and be involved in amending processes if changes were needed. This was to embed a culture of business continuity in the local authority. Providers were also expected to have business continuity plans in place.
