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 local authority understood local, regional, and national risks to people receiving care and support. Risks were identified and managed through proactive risk management, overview and scrutiny.

Safety was a priority for everyone, supported by a culture of openness and learning. People's care journeys were coproduced with people using services, partners, staff, and communities to ensure continuity of care, choice and control, and the least restrictive options were used to promote independence. Funding decisions were agreed in a timely way to mitigate delays in provision of care.

The corporate risk register held oversight of Adult Social Care concerns and actions taken to mitigate strategic and operational risks, and was subject to scrutiny by senior leaders, cabinet members and independent partners. Risks to Adult Social Care service delivery were managed at a departmental level through quality assurance and governance processes, including the recording of mitigating actions and the use of prioritisation tools to analyse and triage concerns.

Data and insight of risk was collated through community engagement. Feedback from safeguarding enquiries, complaints and concerns supported the experiences of frontline teams, partners, and users of services. Identified risks were then analysed for likelihood and impact on financial, physical, reputational, environmental, and service areas.

Policies and processes aligned with partners and enabled shared learning to drive improvement. Information sharing protocols supported safe, secure, and timely sharing of personal information between agencies in ways which protected people's rights and privacy.

The Adult Social Care risk register identified increased service demand, ongoing concerns around waiting lists for assessments, staffing levels, the growing number of complex cases, and capacity in the market to meet demand as areas to prioritise resources and support. Actions taken to mitigate risks were agreed at monthly Quality Assurance and Governance Board meetings, and progress reviewed through weekly senior leader resource meetings, and practitioner forums.

Multi-agency partnerships, use of partnership board structures, assurance and governance arrangements, coproduction, strategic use of finances, and improved workforce development, as well as use of JSNA 2024 data to predict future demand, were all cited as ways to manage risk. For example, in response to waiting lists and increased demand for DoLs assessments the local authority had adopted the ADASS prioritisation tool to identify which applications should be prioritised to proceed to full assessment and authorisation. Staff recruitment, including the role of DoLs operational lead, training of Trusted Assessors, and the refreshed legal gateway panel (to screen more complex applications and reduce the risk of delays), as well as weekly and monthly reviews (including escalation processes) were cited as further mitigation of risk.

Safety during transitions

Care and support pathways were planned and organised with people, together with partners and communities in ways which improved safety across care journeys and ensured continuity in care. There were processes and pathways in place for all major transitions including children to adult services, hospital discharge and reablement, moving out of area, moving between services, and changing from self-funded to funded care. These processes were all linked to best practice guidance's and local authority policies. Process maps were easy to follow and gave good direction for staff and people using services.

Staff told us all referrals for support came through the frontline Family Connect service, who gathered information, triaged cases, and directed them to the appropriate team. This included conversations about the needs of unpaid carers, family members and dependants, as well as the person requesting support. Assessments identified current and future needs and included financial appraisals, contingency planning, and referrals to relevant partner organisations.

Transitions from children to adult services used a 'Preparing for Adulthood' policy which referenced relevant legislation and best practice. Frontline Adult Social Care teams work with Children's services to identify children likely to require ongoing support as adults support to transition to adult services from the age of 14 years old, work with the Special Educational Needs and Disabilities team to establish networks of communication and support. This support included identification of housing, education, training, and employment needs. Named workers to support the person transitioning into adult services, and referrals to relevant frontline teams and partners ensured a multi-disciplinary approach, signposting those who were not eligible for support from Adult Social Care. The Preparing for Adulthood policy outlined the importance of early intervention and a person-centred approach to transitions.

Most people told us of positive experiences of transitioning into adult services, with proactive approaches and appropriate sharing of information between organisations. However, despite the clear processes in place, people also shared poor experiences of transitions, with delays, poor communication, and short-notice housing decisions impacting support. People told us where the young person had a personal assistant in place this was easier to transfer to direct payments as the young person reached 18 than if a personal budget application was a new preferred option to receiving care for the first time.

Partners told us of memorandums of understanding between the local authority and health partners detailing how funding, including CHC funding, was agreed to reduce the risk of delayed transitions.

Safe hospital discharge pathways had been the focus of considerable work, with the ICS highlighting safe discharges and reduced readmissions as a key priority in improving outcomes for people accessing hospital services. Multiple pathways had been agreed, depending on the location of discharge. Pathways were supported by joint working from integrated discharge teams and reablement. Weekly multi-disciplinary team meetings reviewed progress, ensured effective coordination of support, and reviewed long-term needs (including assistive technology options). The Hybrid team then completed a post-reablement review to identify further support needs, with Community Specialist teams overseeing longer-term case management.

Most discharges from hospital were supported by TICAT during people's enablement period. If individuals had long term needs after this period, those were identified by the TICAT team and people would be transferred to the community teams overseeing longer-term care management. Complex needs identified prior to discharge were led by community team case workers who supported the discharge and subsequent enablement support.

People's experiences of hospital discharge and the support received was positive, and whilst discharges to residential and nursing care services took longer, these were managed well and based on outcomes rather than budgets. Long-term placements were only considered after the initial enablement period and following a Care Act assessment identifying long-term needs (in line with hospital discharge pathways).

Autism, learning disability and Mental Health teams, including approved mental health professionals (AMHPs) were part of the Transforming Care Partnership and met with the ICB, NHS England and wider multidisciplinary teams to support people with managing risk of admission and planning timely discharge from hospital. AMHPs (Social Workers who have undertaken further specialised training to become Approved Mental Health Professional) are professionals who assess whether there are grounds to detain people assessed as requiring admission to hospital or mental health secure setting under the mental health act. This applies to people who need urgent treatment for their mental health needs and are at risk of harm to themselves or others.

Mental Health teams worked closely with the psychiatric intensive care units and wider health colleagues to support hospital discharges. Specialist commissioners attended and planned services and any housing need as part of the discharge planning process. On discharge the social work team coordinated community support as part of ongoing monitoring and review. If a person has a period of section 17 leave (if they are high risk and have complex needs, detained on sec 3 of the mental health act) prior to being discharged from a mental health ward, this is monitored, and support is put in place on discharge using a combination of sec 117 after care and Care Act funding to prevent a mental health relapse and readmission to hospital.

Contingency planning

Telford and Wrekin undertook contingency planning to ensure preparedness for potential interruptions in the provision of care and support. The local authority knew how it would respond to different scenarios with plans, including business failures, temporary disruptions in service provision, and planning for emergency evacuation of services. Information sharing arrangements were set up in advance to minimise the risks to people's safety and wellbeing.

The local authority collaborated closely with providers to meet changing demand for services, improve service quality where ratings showed areas of concern, and provided training and information on business viability, including workshops and forums on financial stability to reduce the risk of provider failures. Services were monitored to ensure they were safe, effective, and financially viable. This was done by commissioning and quality monitoring teams who supported early interventions for providers identified as requiring support, worked with providers to resolve service interruptions, and informed senior leaders and relevant partner organisations of progress and actions taken.

In the event of provider failure, the local authority had a duty to meet care and support needs for people and unpaid carers, where the commissioned provider was unable to continue. The duty was temporary and triggered when Telford & Wrekin became aware the provider could no longer execute its support activities. Despite increased demand for Adult Social Care services, senior leaders felt confident there was enough flexibility in the provider market to cover emergency service provision needs and had funding arrangements in place which would avoid delays in the provision of care and support.

Providers told us the local authority's Provider Business Failure and Contingency policy outlined expectations in relation to provider failure, when they should be notified, timescales for action to be taken to maintain service continuity, details of service quality monitoring, and what legislation governed this. People told us emergency provision for unpaid carers was discussed as part of carers assessments and up to 25 hours emergency respite could be accessed per year. Staff told us commissioning arrangements enabled unplanned respite provision for unpaid carers both at home and in residential services.

Staff and leaders told us contingency planning formed an integral part of the commissioning and quality assurance process, with policies detailing full timescales and priorities for how services should operate should there be major disruption. The safeguarding team conducted impact assessments and risk ratings, including detailing how impactful disruption would be to people receiving services. Providers were expected to mirror this process in their own documentation and planning. Service evacuation plans included step by step guides on what to do if a service needed to be evacuated for any reason, and included details needed to be shared with emergency services, as well as detailing places of safety for people to be evacuated to.

Staff and leaders told us there was a civil contingency plan in place (last used during severe flooding in 2020) to allow staff, working with partner agencies, to respond effectively to different scenarios. The local authority's pre-planning and clear lines of joint responsibility allowed staff to quickly coordinate placements and reduce the risk to people.