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

Local authority procedures supported staff in ensuring safety management across systems. For example, a task group in relation to people being discharged from hospital but needing further care and assessment, was led by the local authority with health partners. Its purpose was to take an overarching view of the discharge to assess process and to share experience, challenges, good practice and learning. A co-produced transfer of care process from the local authority to Continuing Health Care (CHC) funding contained clear guidance around transfer of care processes with expected timescales and handover documentation.

Senior staff told us as part of the transformation program, the local authority were aiming to address disparities in hospital discharge services across the county and a new director had been appointed at the local authority to oversee and implement the necessary changes. The goal was to ensure a uniform, high-quality service regardless of location. This involved standardising systems and practices, so resources could be shared effectively, for people to receive consistent care and improve efficiency and resource sharing. Different hospitals used a variety of IT systems and faced unique pressures, including staff shortages and high turnover.

Staff were supported in their roles by processes such as discharge pathways which were broken down by hospital location these had been updated in December 2023. These included reablement, discharge to assess beds, an urgent care response which was a rapid 2 hour service to prevent hospital admission, and virtual wards for people who were medically stable but required further input at home. Data provided information to establish pressure areas in the system including people discharged, length of stays and number of people medically well enough to leave hospital.

Staff discussed approaches to transitions work and challenges in a Community of Practice Forum which helped in connecting operational leaders to the work, but also ensured that everyone was aligned and informed about different aspects of current practice. Staff fed back there were gaps in obtaining support for young people during the transitions process and finding specialist support could be difficult. There was joint working with community teams for people with learning disabilities, occupational therapists, and physiotherapists, although issues with waiting lists and staff capacity persisted. The focus was on tightening the gap in joint working to provide a cohesive service.

Safety during transitions

Improvements were reported as being needed in the effectiveness of transitions services for young people by some people and staff. The process began at age 14, involving families, schools and education. The children's team provided family support until age 18, after which the transitions team took over until age 25 when people transferred to the adults locality teams or Learning Disability and Autism teams. Preparations for adulthood and next steps in college were made, but timely referrals were crucial. Pathway breaks occurred at times due to insufficient time for working on education, health and care plans and explaining the process. Staff also recognised that at adulthood, everything changed, including choices and finances, which were particularly challenging for people and families.

The Transitions team was county wide which staff reported could be challenging but ensured consistency. Data was used to identify young people coming up to 14 years of age. One staff member had been involved in a Preparation for Adults Pilot which was now established, and they were proud of the work they did in supporting young people and families. For example, with assessing mental capacity, looking at benefits and tenancy issues and holding coffee mornings to offer support. This focussed as to where people were on their journey.

Feedback in relation to people and families experience of transitions was mixed. Comments included people had not felt supported, processes could be lengthy and co-ordination could be better. However other experiences were much better including that the transitions social worker was very supportive and the family were able to contact them easily. Another young person's service was increased and the process was described as ‘smooth and efficient’.

One partner felt the transitions team were really good, however there could be some gaps around support for wider advocacy in this area. Other partners told us transitions was an area that was poorly done in many places; however, in Surrey this was an area of high expectation by the local authority and for this to be done well.

In terms of transitions between services such as hospitals this was more positive with assessments completed to support people to return home which recognised their wishes and goals. Feedback from staff in teams was there was good partnership working with health colleagues and close working with the discharge team. Although the work could be pressured at times they felt supported by management and the team. There was time to share information with other agencies and professionals and develop strength based plans.

The role of the Continuing Healthcare (CHC) team was described as pivotal by local authority staff, offering essential support and clarification on responsibilities, to adult social care in complex cases involving health needs. The presence of CHC leads within each area had improved clarity and coordination, ensuring that health and social care needs were better understood and managed.

There were 5 hospitals across the county, each with different ways of working which could pose challenges for the local authority. Various hospitals demonstrated differing approaches to discharge planning and multidisciplinary teamwork with a spectrum of practices and challenges. At some hospitals, the process was less integrated with social care, relying on the A&E team for discharge decisions, with occupational therapy involvement being minimal or as needed. This contrasted with other approaches, where dedicated social care professionals were embedded in the wards, allowing for more direct communication and collaboration with health teams.

Healthwatch had carried out a hospital discharge review following the COVID-19 pandemic and provided feedback to both health and adult social care identifying there was more work to be done in relation to integrated working when it comes to hospital discharge as people who were medically fit to leave, were having to stay in hospital due to adult social care delays.

Other partners felt there could be an impact on rehabilitation beds due to a lack of supportive housing options meaning people could remain in these beds longer and therefore impact on people in hospital.

Feedback from staff was the mental health system was under significant pressure due to a shortage of beds, leading to a revolving door scenario where people were discharged from hospital and often returned. Staff felt effective bed management required thorough assessments and strong co-ordination between home treatment teams and bed management. In their experience, they found good teamwork, support from management, and effective communication were needed throughout the processes. Strong relationships with health colleagues and police support were crucial in managing high-risk situations and ensuring the safety and wellbeing of both staff and people. Staff felt there was good support for mental health discharges and they were able to spend time with people and consider 6 weeks support via the enablement service.

Staff worked creatively to support people with complex needs. For example, one person was unable to return home due to severe hoarding and was provided with a temporary placement with a Shared Lives family. Shared Lives schemes match someone who needs care with an approved carer. This solution spared the person the trauma of the home clearing but also allowed them to maintain autonomy over their situation. By avoiding an abrupt transition and establishing a meaningful connection with others during this time, the person was able to plan for their eventual return home with greater ease and support. This approach highlighted the value of flexibility and personalised care in managing complex discharge situations. Another example was given of a young person with very complex needs who was resistant to going home from hospital initially. They were supported with a live in and night time carer which enabled an ongoing review of their care once at home.

Contingency planning

Staff worked with people to make contingency plans, for example integrating emergency respite arrangements into people's support plans so these were available if required. Some unpaid carers felt there could be more improvements with planning for respite care in unplanned situations and it could be difficult to find respite support. Another unpaid carer expressed frustration as they had been told to come back to the local authority when respite care was needed but they knew their family member did not cope well with uncertainty, so they needed to spend time preparing for this now, and not only when it became urgent.

An unpaid carers emergency plan had been developed along with people with lived experience. For example, detailing people's likes, needs and medication. This gave information to enable people to remain being supported in their own homes if the unpaid carer was ill or perhaps had to go into hospital.

A local authority business continuity plan was in place for any unforeseen events to reduce the effects of any incidents that could disrupt the critical activities of the service and to ensure a smooth return to business as usual. This included a local authority Emergency Management and Resilience Team and a Service Recovery Team to support staff. A Welfare Emergency Response Plan set out the local authorities' arrangements for the activation of staff in order that they could respond to an emergency.

A Provider Support and Intervention Protocol set out the roles and responsibilities of the local authority in the event of serious concerns arising about the quality or sustainability of a care service or provider. This covered joint working with the Care Quality Commission, health and with providers with a focus on prevention. An Emergency Home Closure Protocol with Surrey's Local Resilience Forum (a multi-agency partnership made up of representatives from local public services) was used to respond to an emergency event such as a flood or fire which had affected a care or nursing home.
