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

Safety was a priority for the local authority. Practitioners we spoke with understood where there were risks to people's well-being across their care journeys. For example, frontline staff told us every month they held integrated meetings with health partners, where they reviewed the dynamic support register, which held a list of people with learning disabilities and autistic people who needed support as they were at risk of hospital admissions if they did not receive the right care and treatment in the community. This approach evidenced the local authority's focus on providing a proactive approach with partners, which kept people safer.

Frontline staff gave an example where a person's health had deteriorated, and the person expressed that they did not want hospital admission. In this scenario staff ensured the person had care and support needs and they worked in partnership with appropriate services to provide specialist intervention. This example demonstrated the local authority's approach to risk management in keeping people safe, furthermore, reflected the importance of acknowledging a person's right to choice, in terms of what they wanted to achieve and how they wished to live their lives.

Health partners told us the local authority and local healthcare providers had joined up systems and processes to ensure safe transition and continuity of care, particularly when people were transferring between services. An example provided was the daily 'Sitrep' meetings held between the acute hospital, community trust and the local authority for discharge of patients, from both acute hospital and community beds, with clear routes for escalation of delays and risks. However, a health partner told us about challenges around the shortage of specialist placements, which included supported accommodation, nursing and care home placements. As a result, this caused some delays to discharge, for example people ended up staying as mental health inpatients when they were clinically ready to be discharged.

Frontline staff told us there was a system to track and assess referrals to the children's transitions team, where they attended weekly multidisciplinary transitions tracking panel meetings, which included managers, health teams, the sub-team working with 16-18year olds and the ICB.

The local authority's information sharing protocols supported safe, secure and timely sharing of personal information in ways that protected people's rights and privacy. For example, the local authority used a single adult social care case management system, where people's details, assessments, records of interventions, and performance information was held. Frontline staff told us they found the system accessible and straightforward to use and had support and training to navigate the system. They had read-only access to people's notes on other local health records systems, for example GP and hospital records, which supported greater understanding of the person's needs in some cases. More work was needed around some teams having direct access to detailed health records. Senior leaders acknowledged this gap and were working on plans to improve access, so staff only needed to use one device to access both health and social care records.

The local authority demonstrated alignment of safety management policies and processes with key partners. For example, the local authority had developed a Provider Failure Policy 2024, which was to ensure adults and unpaid carers continued to receive the care and support they required in the event of provider failure, furthermore the policy addressed service interruptions and included provisions for exercising discretionary powers to meet urgent needs.

Safety during transitions

Care and support was planned and organised with people and care providers in ways that improved people's safety across their care journeys. For example, a person told us when they were discharged from hospital the care, they received was timely and person centred. This was corroborated with frontline staff who shared they had a streamlined transition process, where they informed people and unpaid carers when they were passed to the relevant teams, who subsequently reviewed people's needs and care plans. However, whilst the local authority was taking action to reduce waiting times for care reviews, people had to wait for their care to be reviewed once they had returned home.

Whilst we heard positive feedback around transition from hospital to home, in contrast we heard that at times there were challenges when people were discharged into care homes. For example, some providers fed-back that discharge to assess pathways into residential care were complex as it was not always clear whether placements would be funded long-term by either the local authority or the ICB when residents were initially discharged. The local authority were clear however that funding decisions were backdated to the point of placement.

The local authority evidenced their approach to supporting unpaid carers when people being cared for were being discharged from hospital. For example, the local authority had been working as part of NCL on a Hospital Discharge Carers Project. A carer's partner worked together with 5 carers centres to provide a multiagency approach to delivering individualised support to unpaid carers, through the development of a single digital platform to self-refer and find local support services. There was also an enhanced training offer, to support unpaid carers and support safe discharges for the person, importantly to reduce the possibility of hospital readmission.

Frontline staff told us they could access equipment to support young people in transition to adult services to increase safety at home, for example care technology such as epilepsy sensors and falls watches. The occupational therapy had a resource list for staff and could support young people to access phone applications such as relaxation applications and tactile games and similarly, staff gave examples of using charitable funds to provide accessibility technology such as a robotic arm fitted to a wheelchair.

Safety was evidenced as a priority for the local authority, where a person was supported to move into supported accommodation in a timely way, as there were identified safety risks to the person's wellbeing, in their previous home environment. The person shared their experience with the local authority and housing had been exceptional and they felt at home in their new flat. This example also demonstrated the local authority's ambition to deliver an integrated approach with partners to maintain people's safety.

Specific consideration was given to protecting the safety and well-being of people who were using services which were located away from their local area, and when people moved from one local authority area to another. For example, OTs supported people who were placed outside of the borough in placements or where people had moved in with other family members. This approach meant the person had a named worker who maintained contact with them.

The local authority had processes and pathways which outlined the management of continuity of care arrangements and cross-border placements, ensuring safety through coordination across multiple local authorities. There was quality monitoring of effectiveness to ensure out of area placements were safe and met the person's identified needs. Importantly, the local authorities process incorporated the need for staff obtaining informed consent from the person or their guardians, before sharing personal information across borders.

The local authority's hospital discharge processes and pathways were clear, which mostly ensured people were discharged safely. For example, a person's relative told us the local authority acted quickly to support their relative during a hospital stay and afterwards the person was supported almost immediately and was discharged to a respite placement.

The relative also told us the person was fully supported and given information about their transition between services. We were also informed for some people, when transferred from one hospital to another, communication regarding their discharge planning was not transparent with either the person or their unpaid carer. As a result, they were not given information or choices about available support, sometimes equipment had already been installed in their home without their knowledge increasing the risk to their safety and well-being.

A health partner told us there were clear arrangements to ensure safe transition and continuity of care for people on discharge from inpatient mental health services, where weekly referral meetings were held between health and the local authority teams. These provided an opportunity to discuss and prioritise people for support and intervention. However, the local authority recognised transitions was an area for improvement, particularly in services for young people with experiencing mental health.

Contingency planning

The local authority undertook contingency planning to ensure preparedness for possible interruptions in the provision of care and support. This was demonstrated in the Adults and Health Business Contingency Plan, which was updated in February 2024. It included information, procedures and actions to be taken to ensure an effective, timely response to any localised or major incident, which potentially could impact on people's safety.

The local authority had contingency plans where there was care provider failure, which was documented in the Provider Failure Policy 2024. A senior leader told us where care providers had dropped out of the market, they were able to support people where appropriate through 'Your Choice Barnet' which was the local authority's own care provider. This gave the local authority an option to prevent people from going without the care and support they needed. This demonstrated a proactive response and robust contingency approach, which focused on providing continuation in care and support to people, despite disruptions to services.

We heard contingency plans were not always documented. For example, an unpaid carer told us the person they were supporting had a known risk, but there was not a clear documented plan about how to manage this in their social care assessment.
