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

The local authority understands the risks to people across their care journeys, with service risk identified and managed proactively. Waiting lists were monitored and triaged across all teams with management oversight to ensure people with the greatest risk were prioritised. Referrals received by Multi Agency Safeguarding Hub (MASH) were screened as they came in and immediate action taken when needed. Staff told us about a system used out of hours to prioritise and triage cases as they came in, with immediate care plans implemented to manage risk. There was a comprehensive handover process to ensure communication was clear and people were kept safe until longer-term services or support was set up.

Staff in social work teams were trained and able to put in place basic equipment in people's homes to support safety, with equipment being delivered the same or next day in many cases. Safe discharges were promoted by daily huddles within the Transfer of Care Hub (ToCH), with seamless referrals to intermediate care and reablement services.

Information sharing protocols were safe, secure and timely. Teams told us that any suspensions of care providers were communicated without delay, and they would not be able to commission to that service which helped promote safety within their systems. Staff had access to an online provider concern portal to submit any concerns to ensure issues are picked up quickly. The quality assurance team received these and contacted providers to complete a PAMMS assessment if required. Concerns about providers were shared at regular Provider Risk Intelligence Group (PRIG) meetings to ensure that partners were aware of ongoing concerns with providers. Staff told us that some providers were proficient at raising safeguarding concerns, therefore intelligence from the PRIG meetings was disseminated to the MASH and locality teams for action where appropriate. Staff were able to utilise 'read only' access to health partners IT systems to assist with their work in the community.

Leaders told us that all deaths of service users open to the learning disability team were reviewed, to ensure there were safe systems and pathways throughout their care and to highlight any learning to improve the future care of those with additional needs.

The local authority had undertaken a review of the service front door and found that 71% of calls could have been managed differently or avoided. They were working with an external agency to plan changes to improve the experience for people and optimise their 'first point of contact'.

Learning forums had been established by the Principal Social Worker to promote reflective practice, with learning from complaints being shared to improve effectiveness of processes in keeping people safe. This supported the established quarterly social work networking events lead by the NHS Trust, which hosted external speakers.

Safety during transitions

The local authority had protocols in place to commence planning for children and young people from the age of 14 onwards to support transition into adult services, however there were gaps. Staff told us that in practice, work tended to start at around seventeen years of age, with staff reporting they wanted this to start earlier. They told us there needed to be an increased focus on promoting earlier referral with education colleagues to allow more time to plan for provision at the end of education placements. Following the assessment, the local authority told us that whilst pathways are clear to many staff, there can be delays in referrals being sent and an action plan was created in July 2024 to further improve this process.

The local authority was undertaking some work with the assistance of an external consultancy agency relating to the transitions process. A steering group held in April 2024 highlighted that in comparison to children's services data, adult social care systems were not supporting identification and tracking of young people that were likely to be eligible for support under the Care Act. The group found that staff across different services expressed confusion on referral, decision making and the allocation process. At the time of assessment, there was no action plan in place to address this.

Staff reported that direct payments transitioned across the service without issue, however respite provision was a main area of transition which families found difficult, with staff carrying out a lot of work to reassure families. Staff operated a 'named worker' model, alongside the 'staying close' model which provided a 'named personal assistant' (PA) when leaving the care system. Staff told us the named worker and named PA had provided a lot of stability for service users and had reduced the number of safeguarding concerns due to ongoing relationship building. Feedback from people with experience of transitions from children to adult services was generally positive.

Partners commissioned by the local authority to support young carers considered the needs arising during the transition from being a young carer to an adult carer. They linked with partners commissioned to support adult carers and held mixed support sessions when approaching the time of transition between the services. There were plans to extend the transitions offer to carers by introducing a 'boot camp' type of approach for carers aged 18 to 30.

We were told that teams worked closely with partners to manage risks arising from discharges from hospital, however feedback from partners about this was mixed. There were positive examples of working with health partners and staff reported good working relationships within the ToCH. Daily MDT huddles took place to discuss those ready for discharge with no criteria to reside to ensure safe discharge with referrals to intermediate care and reablement services. Staff reported that the interface between health and social care services worked well, and people were positive about their experience of moving between services. However, some staff were of the view that more training should be provided to health colleagues to support their understanding and involvement in mental capacity decisions and completing mental capacity act (MCA) assessments with local authority staff reporting experiencing resistance from health colleagues in completing them. Since the assessment, the local authority told us that the health trust commissioned additional training this year following a learning review from mental health, and support is offered by the Professional Standards team to attend any meetings relating to discharges in the hospital that involve complex MCA decisions and advice, and guidance is offered to both health and ASC colleagues on the MCA principles and values.

Since the introduction of ToCH, data demonstrated a reduction in numbers of patients staying over 14 and 21 days in hospital. At the time of assessment, the local authority had the lowest percentage of beds occupied by 'non-criteria to reside' patients (people ready for discharge) who were delayed in going home within the Cheshire and Merseyside Integrated Care System. Partners told us that there had been improvements in hospital discharge flows due to significant funding allocation, but several issues remained. For example, there were reports of discharges happening too quickly, with fears of potential compromise of patient safety. They expressed concerns about the focus on seven-day discharges as this could pose a challenge if the services the person needed upon discharge did not operate every day, resulting in a service gap and a risk to their safety. They told us the process of brokering wellbeing packages was difficult, with inconsistent commitments to seven-day availability.

Leaders told us when people were placed in a residential placement outside of area, face-to-face reviews were completed for those with complex or specialist nature support needs. If the placement is not within a commutable distance and not a complex case, the local authority requested purchase reviews be completed out by the host authority. Staff told us that there was a reliance on the local authority where a person was placed to provide any intelligence in relation to safeguarding concerns or enquiries. There was no evidence that this arrangement was working to ensure those local authorities were communicating concerns.

Providers expressed concerns relating to discharge from hospital for those having been detained under the Mental Health Act (1983), due to people being discharged without a named Community Psychiatric Nurse or Social Worker. They were concerned that following acute support, people were receiving support from someone who did not know them, and that there was no transition planned when people are discharged and return to the community.

Contingency planning

We were told by leaders that the provider market was stable with vacancies in all areas of provision at the time of assessment. The local authority had in place a business continuity plan in case of events which immediately disrupted functioning in the local authority and were prepared for possible risks in provision of care and support. Policies showed this could require a multi-agency response from all providers of both social care assessment and social care provision and acknowledged in some cases that Corporate Emergency Planning may also need to be activated.