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 had regard to its obligations to ensure safety across all areas of its work and had an actively managed risk register, supported by processes which determined how transition between services, such as hospital discharge, and across local authority boundaries should be managed. The local authority had processes and pathways from first contact with Northumberland adult social care for care act assessments, reviews, financial assessments and carer assessment, with waiting list data for each locality.

There were 'crib sheets', and transfer checklists for managers and staff available to support operational working, so steps and practice expectations across social work and occupational therapy were clearly set out and people were informed when allocated workers were changed. As such, staff understood what the expectations were in practice, limiting the risk of people being 'lost in the system' and people who received care and support knew who they needed to contact if there were any changes in support need.

Northumberland borders Scotland and had established a way of working across its borders and other local authority areas with due regard to legislative requirements, while ensuring people are safe. The local authority recognised they were responsible for meeting the needs of anyone who was "ordinarily resident" in Northumberland, unless they were deemed to be the responsibility of another local authority. The duty to assess a person's needs applied whether the local authority believed that the person was ordinarily resident in Northumberland or not. The main reason for this is to avoid a situation where no local authority assessed where there may be an ongoing dispute over responsibility.

Staff stated that they had the right levels of numbers, knowledge and skills in their individual teams. The County was split into 4 localities, and where the North and West were more rural areas this was reflected in increased staffing levels to keep people safe for assessments, reviews and managing risk. Some members of the local authority's frontline workers and teams had access to 'RIO', the mental health trust system, which helped them to manage risks and support people to stay, or be integrated back into, the community safely. CNTW, the mental health trust, had effective systems and data dashboards, which were shared with local authority staff such as AMHPs, to aid assessments, decision making, and discharges on secure wards and in the community.

NHCT confirmed local authority staff had access to NHS systems, however this was only accessed on a need-to-know basis and where agreed. Access to systems and data were risk managed around patient care, safety, and staff safety. The NHCT confirmed they had a risk register in place. The trust also acknowledged there needed to be improvement within their shared performance matrixes. At the time of the assessment these only worked through clinically ready for discharge reports and more work could be done to improve people's experiences between health and social care.

Safety during transitions

There was communication between the local authority and its partners to ensure people were kept safe through their care journey. There was a clear process outlined for hospital discharges through 'Home Safe' referral processes for weekdays and weekends which was clear to follow, with process maps and good practice highlighting lead roles and how work was allocated. A key focus was safe and timely discharges which optimised outcomes for the people supported.

There was also a mental health liaison process where Northumberland's mental health team worked with people from admission to hospital wards, as part of a multi-disciplinary team giving insight to a person's length of stay, assessment and treatment plan. Not only did this allow for continuity in relationships to be established between professionals and the people being supported, but it also enabled an early view of any ongoing care and support need, once a person was ready to be discharged from hospital.

The local authority had taken a pragmatic response to transitions for young people and this was a key factor in driving the improvement of services. This was supported by a transitional safeguarding protocol to ensure effective and timely referrals between children's and adults services. At the time of our assessment the transition process began with a senior multi-professional forum being convened with children's services and any other services relevant to the young person's care. Young people were allocated to the appropriate frontline team, depending on their needs. The work was governed by a transitions protocol, a transitions dashboard, and a monthly transitions meeting with children's services. NICE guidance was used to benchmark transitions arrangements and a themed transitions audit based on this guidance had been undertaken.

The transitions journey started at 14 years which was felt to be beneficial for young people and gave time to build relationships with a new team. We heard from a young person the transition from children's services to adult social services was smooth. They felt involved and were given all the information they needed. Another person shared with us they felt the allocated social worker was helpful when they had additional queries, and they had provided relevant information promptly. Another young person said the local authority had always intervened quickly in a crisis, supported with care and support, considered their best interests, listened to them, believed and valued them as a young person.

However, a relative of a young person being supported did not feel a future transition for the person was being planned appropriately. The relative told us they did not think there was a plan in place and were worried about this but had been told there could not be a plan until a transition date had been agreed.

The service was not aligned alongside education services, and work was being undertaken to establish a simple response to ensure all transitions were effective. Carers told us young people at 16 were classed as an adult, however, in the educational system they were classed as a child. People told us it could be difficult to know where to go for support, which indicated pathways may not be as clear as they could be and could lead to missed opportunities in relation to ongoing education and employment prospects.

Contingency planning

The local authority understood risks to service delivery and had developed contingency plans to ensure preparedness for possible interruptions in the provision of care and support. The local authority had comprehensive business continuity plans for teams, dedicated 24/7 on-call managers for operational teams, and a vulnerable adults list (VALS) which had been developed to support clients in an emergency response.

There were also contingency, and emergency preparedness plans for provider failure and other disruptions in the provision of care and support. It included examples of when these were implemented, and whether it was effective, with additional information to the business continuity process for external and internal providers such as home care, older people care homes, and independent supported living. The risk of disputes in relation to the provision of care were mitigated due to the joint working arrangements between the local authority and its health partners.

Contingency planning was also in place at a personal level, with people able to tell us they had a contingency plan in place and knew who to contact in an emergency, or if their social worker was not working, to ensure safety and continuity of care. However, it was not consistent, as other people shared how a family member raised concerns and a contingency plan was said to be created in response, and another stating there was no plan in place for them as a carer when they were unwell, leaving a person at risk of not receiving safe care.