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

Staff, leaders and partners told us that safety was a priority for everyone. However, gaps in data and provision meant oversight of safety was inconsistent. Staff and leaders felt there was oversight of safety, but they told us they sometimes had to work around barriers presented to them by shortfalls in data. We also heard from staff and leaders how lack of provision could sometimes cause people to be readmitted to hospital shortly after discharge and the measures being taken to address this through improving community provision had not yet been fully implemented. The local authority did not always have clear visibility of this issue due to gaps in data and data-sharing.

The local authority worked closely with partners to ensure safety in the system with aligned policies and procedures. Joint work to understand and ensure provider quality was well established through the joint commissioning partnership arrangements. We received positive feedback about the local authority's approach, which involved not only professionals, but people with lived experience too who spoke positively about being involved in this work.

The local authority did not have consistent pathways and processes in place for people who funded their own care. The local authority recognised they had a lack of data to understand the experiences of these people, including if there was sufficient capacity in the care market for them. Unpaid carers and partners were not always aware of their right to support with finding care even if they were a self-funder, or that unpaid carers could access support without a financial assessment. This showed this was not working as the local authority had intended, because people and unpaid carers were not always aware of their right to support which could place them at risk of not having their needs met.

Out of hours support staff said there was always cover and there were good links with the weekday services, which joined up with health partners and provided clear processes for staff to follow. There was out of hours support for people who experienced mental health crises, and we heard good feedback from staff about how this functioned.

Safety during transitions

Young people preparing for adulthood had a mix of positive and negative experiences when they transitioned from children's to adult's services. The pathway for young people transitioning to adulthood was a focus of improvement work at the time of our assessment. Partners told us young people and their families experienced challenges when preparing for adulthood. There was sometimes confusion about roles and responsibilities and feedback from staff showed this was consistent with people's experiences. People and partners described gaps in provision for young people after they reached adulthood, particularly in activities and short breaks. Whilst we heard about challenges for young people at transition, the local authority had received positive feedback about the process following recent improvements. We saw examples of multiple compliments from parents and providers about transition.

The local authority knew this was an issue and leaders said they wanted to get to a position where planning for adulthood started at an earlier stage, with a clear process and support in place for young people and unpaid carers. The preparing for adulthood strategy ended in 2023 and work was underway to develop a new strategy with children's services and partners. A December 2023 joint inspection by CQC and Ofsted of the local authority's special educational needs department (SEND) identified a need for earlier planning to ensure a more effective and efficient transition to adulthood. Leaders acknowledged a need to prepare young people and their families at an earlier stage and improve the links with children's services.

There was a team who assessed young people as they transitioned from children's services to adult social care. There were regular meetings between teams in Children's and Adult's services for planning, which usually started from 16 and a half years old. Where a young person had particularly complex needs then this work would start sooner. In mental health we heard that sometimes referrals came late to the CMHTs, which left the team with less time to prepare. There was also sometimes uncertainty about funding for children reaching adulthood, with staff not always knowing at an early enough stage whether funding should be joint with health.

People's experience of hospital discharge varied; teams often achieved good outcomes but where people had complex needs there were sometimes challenges. Hospital discharge teams worked with people when they were ready to return home. There were defined pathways for people depending on their level of need which staff understood. Staff described good links with health colleagues as well as the locality teams to ensure continuity of care and oversight when people returned home. The local authority used a 'home first' model for hospital discharge and this had been a focus of improvement work. The local authority had invested in community capacity and improved systems for accessing brokerage to increase the options available at discharge. Local authority data from November 2023 to October 2024 showed increased access to 'home first' support and improving outcomes for people who received reablement, with people requiring fewer care hours after a reablement intervention.

Staff also told us gaps in homecare provision had led to people who could be supported back to their homes needing to be discharged into care homes. The local authority was aware of the high demand for reablement or community-based care and told us they had commissioned homecare providers to address this, as well as implementing new approaches to commissioning which were aimed at improving capacity in more rural areas. The feedback we received showed this had not yet fully met this unmet need.

Partners said there were sometimes challenges in finding the right provision where people required residential care for complex needs, such as for people living with dementia. This meant people on these pathways could sometimes face delays to their discharge home. However, most feedback was positive and partners described a good choice of residential provision for people with a variety of complex needs related to their mental health, a learning disability or autism.

People were rarely placed out of the county unless it was their choice to do so. Where people were placed in provision outside the county, we saw there were systems for monitoring these placements through reviews and quality checks. Work was underway to get reviews up to date and people placed out of county were being prioritised in this work due to the potential risk.

Contingency planning

There were plans in place to respond to any urgent or unforeseen interruptions to service delivery. The local authority knew how to respond in certain scenarios, such as extreme weather or service failures. There were processes in place for staff to follow and these had been recently reviewed.

The local authority had a business continuity plan regarding all its services and for adult social care there were processes to follow in the event of a providers closing due to ceasing business, CQC enforcement activity or events such as fires or floods.
