Safe pathways, systems and transitions

Score: 4

4 - Evidence shows an exceptional 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

People told us very positive accounts of their experiences of moving through their care journeys. We heard excellent accounts of planning for the future well in advance of any changes, from both carers and from people in receipt of care and support. We found the proactive relational nature between local authority staff and other providers allowed safety in transitions across the board. One case referenced 'thoughtful planning' in planning for the future and we found this consistently in the evidence we saw and heard from people. Demographics in the local authority meant transitional arrangements were a high priority in terms of prevention of escalation of future need. There was a lot of multi-agency working and a high risk panel, which effectively met needs early. There was focussed work to prevent their care-leaver population becoming part of their homeless population between adult social care and children services.

Providers and partners reported systems were safe and well planned and we found the out of hours service supported emergency arrangements and safe transitions between services. For example, we saw the emergency placement flow chart and process maps and staff and partners said this was implemented and worked extremely well. Providers and health partners said they were involved with the prevention agenda and safety management. For example, there were multi-disciplinary meetings for people with complex needs: when people were not known to social care, they were then identified through these arrangements. The high-risk panel also involved external partners such as the police which worked very effectively. We saw effective governance procedures were in place around provider oversight and provider concerns with escalation processes mapped out and we heard from staff and partners these were used effectively and appropriately. Staff said the test and learn pilot of the 'front door' arrangements had been intended to further join-up support so people would not need to tell their story more than once. Staff positively referenced the pilot of the east integrated neighbourhood team with health colleagues, they said it reduced handoffs, improved efficiency and supported safety across the care journey for people. There was trauma informed guidance on safety, trust and transparency throughout the co-production process. Guidance for staff also described how the provision of supervision and peer support better enhanced safe and effective practice and staff reflected consistently this was evident in their practice.

All people waiting for a community DoLS (deprivation of liberty safeguards) decision were appropriately allocated to a neighbourhood or specialist team, discussed with the line manager and the DoLS team and monitored through a tracking document. With no waits for standard DoLS or other safeguarding inquiries, we found the local authority to be very effective in managing safety around safeguarding. There were sufficient staff trained and supported as best interest assessors and they were supported by robust procedures.

Safety during transitions

The local authority ensured safety during transitions and continuity of care during referrals, admissions, discharges and transitions between services. People consistently reported positive accounts of the support received during transitions. There were no waits for hospital discharges and therefore flow through the system was well managed. Social workers were based in local hospitals and had high numbers of successful discharges. Good communication was reported between disciplines and staff consistently reported the multidisciplinary teams (MDTs) and the neighbourhood teams worked very well. Weekly MDTs took place with health staff where workers self-allocated cases and all parties took a strength-based approach to working with people. All staff we spoke with described excellent coordination across system partners and internal teams with no barriers to information sharing or joint working in service of people needing care and support. We heard from staff about work within a hospital where daily meetings with discharge planning teams and ward meetings involved them consistently. There were good relationships between out of hours teams, rapid response teams and district nurses at the weekend. For example, when people had been discharged home and they required reablement, out of hour services were able to put the support in place. Providers said, because there was effective communication between social workers and NHS trusts they had never had an unsuitable or 'unsafe' hospital discharge. They reported miscommunication didn't happen in the local authority and teams worked effectively to ensure the safety of people.

Regarding safety during waiting for occupational therapy assessments, detail about a triage system was provided which mitigated risks appropriately. Occupational therapists were based in neighbourhood teams and were local to their population, however they had their own duty team across the local authority. Having one central waiting list enabled them to work together, manage risk and prevented information being lost. A dashboard had been introduced to prioritise cases in social work teams and to mitigate risk. Staff said it had enabled them to improve monitoring of cases and provide a responsive service. The duty system also effectively allowed risk to be managed for unallocated cases and highlights from the dashboard were shared with frontline staff in supervision.

Transitional arrangements for young people were excellent. Partners said consistently the 'planning together' meetings were used effectively to meet the needs of a young person. The 'good life steering group' placed young people at the centre and afforded them choice and control over their future. We found these forums also supported strong relationships between the local authority and providers and a collaborative culture within the sector. We heard about workshops for parents and carers around subjects relating to transition and service providers such as internships, education and workplace opportunities were clearly provided and available. Young people were supported for transitions at age 14, and at age 16 for handover to health services. Although there had been cases which were held until the person was aged 25 and a half, this was very unusual. This collaborative planning was proactive, person centred and involved and supported parents and carers and the individual to choose the best outcome available from a healthy market offer.

Contingency planning

Provider failure and service interruption procedures were in place and updated in July 2024. Staff and leaders explained what they would do and what they had done in cases of provider failure. Partner feedback demonstrated the local authority were responsive and supportive in planning for and responding to difficulties. There were mutual aid arrangements in place with neighbouring boroughs and the 5 borough NCL arrangement supported joint working and support across local authorities in times of disruption or emergency. Leaders and staff told us about home care mutual aid across neighbouring local authorities.

There was an example given of effective response to disruption: a care setting experienced extreme effects from heavy rain. The local authority provided swift action in keeping residents safe and identified solutions quickly for displaced residents. They also evaluated their actions following the incident which led to the development of a specific emergency placement flow chart and protocol. There was a joint business continuity plan for staff teams which detailed scenarios of potential disruption.