# Safe systems, pathways and transitions

## Indicative score:

**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.”

“I feel safe and am supported to understand and manage any risks.”

## 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

There was a significant backlog of approximately 217 young people aged 18 and over who were on the waiting list for assessment by the Transitions service. An action plan was in place to reduce this by December 2023. A plan was also in place to reduce the waiting time post referral to ensure that young people received a safe transition when moving between Childrens and Adults social care services.

Young people in the Youth Empowerment Squad were extremely positive about the benefits of the Preparation for Adulthood and Transitions service, which aimed to ensure continuity of care during the transition from child to adult with care needs. They told us of their personal success stories, of their broadened horizons and new confidence. Bringing together the Preparation for Adulthood and the statutory Transitions service to bridge the gap mitigated some of the risk and reduced pressure on formal assessment and care services.

The Early Intervention and Community team worked smoothly to bridge the transition between acute hospital health services and community-based health and social care services.

This integrated team worked within shared pathways and communicated effectively to make the most efficient use of resources. Assessment documentation was shared so that people did not have to repeat their stories, to obtain the help and support they needed.

The single point of access ensured that people who had either been referred to, or contacted the wrong service, were referred onwards to the correct service rather than just signposted, so to the public, there was “no wrong door.”

There were frequent, regular multi-disciplinary conversations and meetings to ensure that people moved smoothly at the earliest opportunity from acute hospital services back home. This integration of health and social care at the point of discharge from hospital worked well to reduce length of stay, provided appropriate rehabilitation and reablement, and reduced likelihood of readmission to hospital.

The process to discharge homeless people to a temporary accommodation-based service where they could have a Care Act assessment provided a safe transition for those who met the eligibility criteria.

Feedback from providers was that transitions from one service to another because of changing needs, or avoiding a move where this could be safely achieved, were inconsistent, and that it could be hard to get a social worker to support with complex cases.