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

Safety was a priority for everyone at Westminster. The local authority understood the risks to people across their care journey. Risks were identified and managed proactively and the effectiveness of these processes in keeping people safe was routinely monitored. The views of people who used services, partners and staff were listened to and considered.

The local authority had been working proactively with health partners around winter planning. There had been a Winter plan for 2023-2024 which had focused on early intervention and prevention and addressed inequalities and wider determinants of health. The plan included safety planning around the cost-of-living crisis and offered warm spaces to reduce loneliness. Hot food and drink provisions had been available to support people through the food bank provision and free school meals. Hardships funds and grants and prepaid energy vouchers had been issued to support people with the cost-of-living increase.

Frontline teams told us they had access to shared information systems and felt this had been useful in connecting the hospital teams, as they operated across the different Borough sites. The teams highlighted a shared database with NHS and social care teams was an area for improvement moving forward. Senior leaders explained the shared recording system with the external OT provider was working well as this supported a person-centred approach and best practice.

One provider explained they had a shared integrated system with the local authority, which had been functioning well. There had been further discussions on future technology, for example a chatbot function when unpaid carers needed support out of hours. There have been conversations with unpaid carers on what works for them, and this has been work in progress with the local authority, who have been supportive in improving and developing technology to support unpaid carers and their families.

In practice the local authority had a comprehensive Standard Operations procedure, which detailed the discharge planning process and the joint approach with health and social care to provide support and prevent re-admission. The local authority recognised individual roles and responsibilities within the discharge process, for example the role of the single coordinator who facilitated a system to secure safe and timely discharges on the appropriate pathways.

Safety during transitions

There was evidence that the local authority had safe systems and pathways. For example, there was a clear referral and allocation process for people coming into the Reablement service, whether this was through the Advice and Information Team, or a referral from hospital discharge or community social work teams. The service was focused on the preventing, reducing and delaying the need for care and support. There was a strong emphasis on being person centred and enabling people to regain independence. There was a flexible and responsive approach to care and support planning and delivery, for example through provision of equipment, online shopping, home adaptations and telecare.

Most of the feedback from people was positive. One person told us there was a partnership approach to the care they required to support their discharge needs and provided the example of working with the reablement teams, occupational therapists and physiotherapists. The person felt able to discuss and advise on steps to support their own ongoing health needs. Another person told us the reablement care had been arranged immediately after discharge and they had found the reablement service helpful. In contrast, another person told us the OT home assessment took 2 weeks and then they experienced a delay in receiving the equipment, which arrived 3 weeks later. In the interim, they were issued with mobility aids when discharged home and had physiotherapy intervention, which supported them to regain skills in managing the stairs at home.

Partners told us that the local authority supported safe discharges from hospital to care homes. Frontline teams noted discharge hub meeting with health teams took place twice or three times per week where they discussed people who were medically ready for discharge or those required an allocated worker. The allocations were screened on duty daily. The delays to discharge were related to people waiting for equipment. This was not always due to equipment delivery issue, but stock related, and the teams felt this had improved recently.

Frontline teams described the Telecare service as positive and they regularly communicated with the teams around the provisions that were available. Frontline teams had a support worker who managed practical tasks, which included supporting people with key safes and shopping. Staff referred to this as a practical and essential service which supported peoples discharge journey.

There is evidence that the local authority had safe systems and pathways through its Preparing for Adulthood Protocol. The Learning Disability service worked jointly with health partners, Children's services, Education and Special Educational Needs and Disabilities, to support young people who had an Education, Health, and Social Care Plan with transitions to adulthood.

The Transition team tracked young people who were likely to need Adult Social Care services and started planning for their transition from the age of 14. The transition team was co-located with the Learning Disability Community Health Service which supported to maximise knowledge in sharing and coordinating support. The frontline teams we spoke with had a very empowering approach to the transition process and were able to explain the transition pathways clearly.

There were different stages of transition depending on the age of the young person which the team displayed good knowledge of, ensuring there was a clear proposed plan in place once the young person became an adult. The team participated in tracking meetings held every 8 weeks. It was explained that these meetings were multi-disciplinary meetings whereby representatives across various local authority teams attended to discuss cases. This helped planning for expected workloads for transition cases. One provider told us the transitions team were exceptional and were committed to effective transitions.

The frontline team working with autistic people and people with learning disabilities supported with the transitions process. They described work carried out by specialist transition workers earlier in a young person's life and transfer to their service at around age 17. There were no known problems with the transition process and the team felt it worked well. There was a commissioned provider to support people transitioning from Children's services to Adulthood which had supported a person-centred approach.

One unpaid carer noted the support from the worker had made all the difference in the transition journey. Children's and Adults Teams worked very closely and there were systems in place to share information where appropriate. The team explained that when a young person was on a child protection plan, they were seen as priority. Safeguarding concerns that were outstanding were managed by the adults safeguarding team. The team explained that they looked at preventative measures when supporting families going through transition and ways to prevent safeguarding concerns was part of the assessment process.

As part of the local authority improvement plan, there was focus on further enhancing the model of transitional safeguarding in partnership with the Local Safeguarding Children Partnership. The local authorities plan is to develop the transitional safeguarding framework to improve the experience and outcomes for young people with high levels of risk and vulnerability when transferring across services into adulthood.

There was good community support which the frontline teams identified as being particularly important. Parents were able to attend parent participation groups, which gave them the opportunity to learn from other like parents going through similar processes. The team provided necessary information to parents as part of the transition process. For example, the teams held sessions with the young person and family to provide reassurance and prepared them for the changes when they transitioned to adult services.

The local authority had a dedicated autism social worker in the team who supported with making reasonable adjustments in the assessment and care planning. There was also a pathway for autistic people and people with a learning disability for planned or unplanned hospital admissions. The team we spoke to noted the need for ongoing work around transitioning young autistic people with the Westminster employment service. Plans were in place to meet the needs of young people transitioning and the team we spoke to felt able to meet the increase in demand. They noted a plan to introduce autism navigators based in adult social care teams. The local authority used a forward-thinking and person-centred approach, though listening to the needs of young people and their families. This was central to making their preparation for adulthood meetings effective and help to continue placing the rights and wellbeing of young people at the heart of their service provision, irrespective of age.

We received positive feedback about transition from child to adult services where communication and support from staff was helpful. However, the paperwork and application process was difficult to manage due to the change in legislative criteria.

Another person shared a strength-based assessment was completed jointly with children's services to support the transition of care needs. The transition meetings were held over a period of time, which enabled the person and their carers to get to know the new adult social care worker as well as the processes. The worker had identified a new service as the previous service ended at age 16 and a smooth transition was completed. This approach ensured that appropriate services were in place and the funding of support was taken over smoothly upon the person reaching 18.

Contingency planning

The local authority had its own emergency plans for service disruption which included a Continuity of Care process which had set out procedures to ensure that the persons care and support continued without disruption, during and after a geographical move.

A partner shared the local authority had a collaborative approach about emergency plans and winter plans and informed and involved providers in a timely manner. There was also a Provider Services Business Continuity Plan which documented the actions to be taken to minimise disruption in the event of either a foreseen or unforeseen disaster. The most common risk of provider disruption in Westminster was caused by the frequent major events which brought large crowds which lead to road closures and disruption to transport. Most of the events were annual and planned and had been managed. To ensure people did not experience any gaps in service provision unpaid carers were issued with access passes or supported by Security Cordons. The local authority had in place the Emergency Response Description and Data service, who provided welfare and safety checks to people who had not responded to homecare services. However, some carers told us there was not a plan in place if they were unable to fulfil their caring role at short notice.

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