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 and other system partners prioritised safety. They understood the risks to people across their care journeys which were identified and managed proactively. They had mapped the pathways for transitions people experienced, and through standard operating procedures, detailed process maps and dedicated teams, built a robust framework for managing transitions effectively. They said through collaboration, best practice models, and a person-centred approach, they aimed to uphold the highest standards of care and support throughout the transition journey.

For example, staff told us although there were internal key performance indicators for discharging people from hospital in a timely manner, risk was a major consideration at every point of the discharge process. People would always be risk assessed to ensure their safety, informed by a multi-disciplinary team (MDT) which included both health and social care perspectives.

Where more than one organisation was involved in delivery, policies and processes about safety were jointly developed, and there were opportunities to share learning and drive improvement through partnership and governance boards. Some services were integrated, whilst others worked in close partnership in relation to transitions or joined up working.

It was clear information sharing protocols had been considered, and supported safe, secure and timely sharing of personal information in ways which protected people's rights and privacy.

Safety during transitions

Care and support was planned and organised with people, together with partners and communities in ways which improved their safety across their care journeys and ensured continuity in care. This included referrals, admissions and discharge, and where people were moving between services.

Transitions between children's and adults' services were managed by the Preparation for Adulthood team. This team worked with people from the age of 17 until 25 or earlier if they left education. At the point of leaving education, young adults would be transferred to the appropriate adult team for ongoing social care support. Staff told us there was good partnership working with education, health, police, housing and other agencies.

There was a legal framework for the transition process which started at 14. Children's services presented information to a multi-agency panel, according to identified needs and the age of the young person. The more complex a young person's needs, the earlier their circumstances would be brought before the panel for planning to start.

Children and young people with more complex needs, who were more at risk of being admitted to long term health care provision were considered monthly and would be rated according to risk and urgency.

Staff also cited examples where, due to a breakdown in family relationships or a crisis in a young person's health, they were brought at short notice to the panel, which met regularly, but could also be summoned ad hoc. There was a strong sense of partnership between different agencies and different teams within the local authority in the service of meeting the needs of young people. They communicated effectively and were responsive to each other. The hospital team, out of hours teams and housing worked with social care services and others to provide the most effective response in a timely manner.

A young person we spoke with was very positive about their experience of transition from children's to adult's services. They reported the assessment included the views of people who were important to them, at their request. The placement identified was nearer to valued family members, promoted independence, enabled attendance at college, and made the person happy. Family members had not however been offered a carers assessment and did not know what support was available as an unpaid carer.

There was an integrated discharge team at the centre of safe transitions which was constantly in contact with social care to ensure transitions from the acute hospital to the community were seamless.

Local authority staff attended a multi-agency meeting with health and care provider colleagues 7 days a week. All patients who were medically fit for discharge from the hospital, and in rehab beds were discussed, as well as more complex cases when needed. The local authority provided expertise and appropriate challenge in discharge planning for patients and was seen as a key component to MDT working in the discharge hub. The aim of these meetings was to ensure people were on the right pathway and to review where care processes were up to. There was a second meeting at the end of each day to review any cases which had not been progressed or faced unexpected barriers to discharge.

The Bridging Care service was effective in ensuring same day discharges for people who could go home to their previous address but had some additional care needs. This service was provided for up to 5 days post-discharge, to allow for longer term provision to be arranged.

Health staff said they also had good engagement from the local authority to support the flow from rehabilitation and intermediate care placements to longer term care arrangements.

One partner said there were clearly established processes to escalate delays or discharge queries. The local authority team was found to be responsive and to proactively engage with patients to support discharge as soon as safely possible. A senior health leader said every patient had an identified social worker, not just a team. They reflected the social workers were more rigorous than they had seen before. They said the social worker communicated with everyone and continued the conversation until all issues were resolved, never leaving an unresolved problem or an unhappy patient. Any impact on family members and unpaid carers of discharge plans would be incorporated into this discussion.

Staff told us in cases where interim support was required for a person with learning disabilities or autism, the appropriate response depended on how the need was identified. If a referral was received under the Discharge to Assess (D2A) process, typically accompanied by an occupational therapy report, efforts were made to adhere to the recommendations and implement services required. The social worker usually aimed to visit the resident as soon as possible.

A health partner said local authority staff had a problem-solving approach which enabled further collaboration and ongoing development of our services and processes. The team were open to challenge and would support and guide the discharge process. We heard the managers communicated regularly and were actively involved in supporting the Hillingdon Health Care Partnership. They also told us the local authority had been fully engaged with moving towards using a digital discharge patient tracker (OPTICA). It was hoped this would reduce duplication of work, removing waste of meetings, and streamline the communication related to patients' assessment, discharge planning and discharges in which ASC participation and engagement is key.

We also heard separately, of local authority involvement in a “Christmas Eve” initiative, to identify and address system blockages which delayed discharge. The local authority had facilitated a change in process, whereby if a social care assessment was completed, if it was safe and appropriate to do so, the outcome could be shared verbally, and next steps initiated whilst the documentation was written up. This reduced the time taken to get patients discharged which enabled people to return home or move to their next place of care sooner. The rigorousness of assessments and understanding of the person’s circumstances mitigated against unsafe discharges due to poor planning.

Specific consideration was given to protecting the safety and well-being of people who were using services which were located away from their local area, and when people moved from one local authority area to another. The local authority told us when individuals moved to another local authority, their approach involved close collaboration with the relevant authorities. They noted their procedures facilitated seamless transitions and ensured individuals continued to receive the necessary care and support during the transfer process. This included bridging services to maintain continuity until the new host authority commenced provision.

Where an individual was no longer able to self-fund their care, the local authority's procedures included provision to support them through transitions in care. This involved exploring alternative funding options, accessing community resources, or facilitating transitions to appropriate care settings while maintaining continuity of support.

Contingency planning

The local authority undertook contingency planning to ensure preparedness for possible interruptions in the provision of care and support. They had a provider failure procedure and were able to evidence how this had been used to ensure the safety and continuation of care provision for residents. The local authority knew how it would respond to different scenarios; plans and information sharing arrangements were set up in advance with partner agencies and neighbouring authorities to minimise the risks to people's safety and wellbeing.

A senior leader in health advised there were never any disputes in Hillingdon as to who paid for care. The local authority moved the person then negotiated behind the scenes without impacting on the patient or flow. The local authority told us they had implemented measures to prevent financial disputes. In cases involving Continuing Health Care (CHC) funding, adult social care conducted assessments and made placements simultaneously, completing checklists and making decisions without prejudice to ensure safety and continuity of care. They held a weekly CHC panel where cases are presented and discussed, and in emergency situations, cases could be presented outside of the panel.
