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 understood the risks to people across their care journeys. Risks were identified and managed proactively, and the effectiveness of these processes in keeping people safe was routinely monitored. The views of people who use services, partners and staff were listened to and considered. The local authority recognised delays in assessment and support as a key risk and aimed to improve through better oversight and review of duty systems. These measures helped ensure smoother and more responsive transitions in care, especially at key life stages. For example, the Adults Quarterly Report highlighted that oversight of duty systems was strengthened to reduce delays and improve responsiveness. This meant people experienced fewer gaps in care and safer transitions.

Risks during short-term care and discharge transitions were also identified. Service concerns showed that reablement services received 16% of Richmond's concerns, with issues such as failed visits and poor communication. Actions were taken to reduce missed or late appointments, which reduced risk during recovery periods and improved safety for people returning home.

Staff feedback confirmed that safety was prioritised during urgent situations. For example, emergency duty teams described how they constantly re-prioritised according to risk, focusing on safeguarding and Mental Health Act assessments. This approach ensured that people in crisis received timely intervention, reducing harm and maintaining dignity. Staff also gave examples of escalating care when transport was unavailable for a person at risk of homelessness, which prevented exposure to unsafe conditions.

Partner feedback was mainly positive, and we heard that assessments were detailed and changes in need were addressed promptly, with providers notifying via the provider portal or in an emergency to duty. However, some partners' feedback reflected concerns about prioritisation. For example, some providers said emergency responses were not always effective and that focus appeared greater on hospital discharges than care homes. This suggested there may be some inconsistency in the local authority's responsiveness. However, we found the local authority had measures in place to address these concerns, such as through the improvements in performance around reviews and in safeguarding pathways.

Risks identified by the local authority included delays in assessment, missed visits during reablement, and lack of emergency resources out of hours. These were managed through improved oversight of duty systems, monitoring service concerns, and strengthening rapid response services. For example, the rapid response team achieved 96% of calls within the two-hour expectation, preventing unnecessary hospital admissions and keeping people safe at home. Monitoring through quarterly and end-of-year reports ensured actions were tracked and improvements sustained.

Policies and processes about safety were aligned with other partners involved in people's care journey. This enabled shared learning and drove improvement. The local authority worked with health partners to align urgent care responses. For example, the rapid response service partnered with ambulance teams to stabilise people at home and avoid hospital conveyance. This collaboration ensured timely intervention and reduced disruption to people's lives.

Information from national health checks showed strong mechanisms for staff to raise safety concerns and fair case allocation, supporting shared accountability across agencies. These processes helped reduce avoidable harm and delays during transitions, demonstrating that alignment with partners improved outcomes for people.

Information sharing protocols supported safe, secure and timely sharing of personal information in ways that protected people's rights and privacy. The local authority used the Better Care Fund to develop mechanisms for sharing information across health and social care. For example, summary documents showed improvements in secure data exchange, which supported coordinated care and reduced duplication. This meant people experienced smoother transitions and avoided unnecessary assessments, protecting their privacy while ensuring timely support.

However, feedback from emergency duty teams indicated gaps in communication with daytime teams, as handovers relied on system notes rather than direct dialogue. This limited opportunities to clarify urgent issues, which could affect continuity of care. Addressing these gaps would strengthen information sharing and further protect people's safety.

Safety during transitions

Care and support were planned and organised with people, together with partners and communities in ways that improved their safety across their care journeys and ensured continuity in care. This included referrals, admissions and discharge, and when people were moving between services. Transitions from children to adults' services were not consistently planned or supported. Evidence showed that when young people turned 18, many of the clubs and breaks they previously attended stopped. For example, unpaid carers told us all activities their family member attended before adulthood disappeared once they reached 18. While some families received direct payments to arrange additional care, this placed responsibility on unpaid carers to fill gaps. This created uncertainty and additional pressure for families, reducing continuity of care and limiting opportunities for young people to maintain social connections and independence.

The local authority explained that a separate protocol and pathway for transitions had been co-produced with young people and their families and partners. The transition protocol included five core principles to support transitions between children's and adult services including personalisation, preparation, transparency, independence and partnership. The transitions pathway was monitored by a specialist Transitions Board which included two parent carer representatives. Staff worked closely with colleagues from Achieving for Children to make the transition as smooth as possible.

Transition arrangements were generally well planned, with structured tracking processes, regular multi-agency meetings, and strong collaboration between children's and adults' teams. Staff provided examples of successful transition work including supporting young people into supported accommodation and meaningful employment. However, we found support during transition was not consistently effective. People's experiences varied with some reporting positive support and others highlighted difficulties accessing specialist services and a lack of a multi-disciplinary approach. Communication with carers was also highlighted as an area that could be improved. Partner's experiences also varied with some reporting positive experience of transition however some partners reported fragmented provision within mental health services, which weakened outcomes for young people and left some feeling unsupported. Although planning pathways existed and were routinely reviewed, impact on people varied, in particular for young people with mental health needs, whose experiences remained inconsistent.

Processes to support safe hospital discharge were in place but varied in effectiveness. The local authority recognised delays in assessment and support as a key issue and aimed to improve oversight of duty systems to ensure smoother transitions. For example, quarterly reports highlighted actions to reduce delays and improve responsiveness at key life stages. These measures aimed to reduce risks associated with delayed discharges, supporting people to return home safely and avoid unnecessary hospital stays.

Reablement services played a role in supporting safe discharge, but concerns were raised about communication and missed visits. Service concerns reports showed 16% of issues related to reablement, including failed visits. Actions were taken to monitor and reduce these issues, which improved safety during short-term care and discharge transitions. Addressing these concerns reduced risks during vulnerable recovery periods and supported better outcomes for people leaving hospital.

Partnership working through urgent community response services also helped prevent unnecessary hospital admissions. For example, the local authority told us a rapid response service achieved 96% of calls responded to within two hours, stabilising people at home and avoiding conveyance to hospital. This enabled people to remain in familiar environments, reducing stress and promoting recovery.

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. There was limited evidence of structured arrangements for people placed out of area or moving between local authorities. Staff described situations where they relied on negotiation with families when resources were unavailable, such as when a person returned to an unsafe home over a weekend. This reliance on informal arrangements increased risks for people and placed additional pressure on families.

There was no evidence of a consistent approach to providing named workers or advocates for people moving between areas. Emergency duty teams reported challenges in accessing resources across local authority boundaries and highlighted that they often had to escalate issues without clear pathways for inter-authority communication. This lack of coordination could lead to delays in care and increased vulnerability for people during transitions.

Emergency duty teams prioritised safeguarding and Mental Health Act assessments but faced resource constraints, particularly out of hours. Digital care technology was available, but the absence of a responder service which could be accessed by everyone in Richmond meant some people could not access out of hours support, increasing the risk of unnecessary hospital admissions.

Contingency planning

The local authority undertook contingency planning to ensure preparedness for possible interruptions in the provision of care and support. 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. The local authority had a structured approach to managing risks and emergencies. It developed a range of policies and plans to ensure continuity of care and support during disruptions. For example, the provider failure procedure, reviewed in December 2023, set out clear definitions of provider failure and included immediate actions such as forming a multi-agency steering group to coordinate responses. This group involved health, social care, commissioning and quality assurance leads, which helped reduce delays and confusion during critical incidents. This meant people continued to receive safe care even when providers could not deliver services.

The local authority also created a comprehensive resilience policy and plan in 2024. These documents outlined processes from emergency response through to recovery and regeneration, with defined roles and responsibilities for all stakeholders. For instance, the resilience plan included action cards for each role, from strategic to operational levels, ensuring clarity during emergencies. This supported timely decision-making and reduced risks to people's wellbeing during service disruptions.

Further measures included a humanitarian assistance plan, which provided for psychological first aid and practical support for people and families affected by major incidents. For example, the plan required the immediate set-up of a humanitarian assistance steering group following a disruption. This approach helped people feel supported and safe during stressful situations.

The local authority also tested and reviewed its business continuity plans regularly. For example, the commissioning continuity plan identified risks that could affect service delivery and outlined immediate and longer-term actions. Staff were able to work remotely if needed, and emergency lists of people receiving services were available in case of IT failures. These steps ensured people continued to receive essential care without interruption.

Partners confirmed the effectiveness of these arrangements. For example, a voluntary sector partner reported that emergency respite was arranged quickly for a person after several falls in one week. This change in environment supported the carer, ensured the person's safety and helped the local authority assess ongoing support needs. This demonstrated that contingency planning had a positive impact on people's safety and wellbeing.

Funding decisions or disputes with other agencies did not lead to delays in the provision of care and support. Evidence from policies and partner feedback indicated that the local authority prioritised people's needs over organisational disputes. For example, the resilience and recovery plan, developed in collaboration with key stakeholders, included clear objectives to maintain essential services during emergencies. This meant that disagreements about funding or responsibilities did not delay care. Instead, the local authority focused on joint working and rapid decision-making to ensure people received timely support.