Northumberland County Council

NHS Northumbria Healthcare NHS Foundation Trust

Northumberland Transitions Policy for Children's and Adults Social Care

This document provides good practice guidance and an operational framework for both children's and adults staff who are working with children and young people who may be eligible for adult social care services. It covers important elements of transitions work and the responsibilities of both social workers in the Children's and Adults Social Work Teams for the planning of the successful transition to adult services.

1. Statement of Purpose

The protocol to which this guidance relates is aimed at those working with young people such as:

- Looked after Children (LAC) with disabilities who leave care at age 18;
- People with physical disabilities and long term health conditions;
- People with learning disabilities and/or learning difficulties;
- People with mental health conditions;
- Sensory Impairment
- People with Autistic Spectrum Conditions (ASCs);
- People with Emotional and Behavioural difficulties; this includes recognising the impact of ACE's which may lead young people to have needs for care and support as adults
- Vulnerable Young people and Vulnerable Adults.
- A history of Substance Abuse or Forensic Services
- A young person (aged under 18) who is at risk of harm or abuse and who is identified as continuing to be at risk into adulthood

1.1 What is a transition protocol and why do we need one?

The multi-agency transition policy has been developed with the primary purpose of supporting the systematic and consistent delivery of positive outcomes for young people in transition in Northumberland.

The legal basis for the work of transitions is found in The Care Act 2014 Chapter 1 Sections 58 – 66. The Care Act (2014) gives young people who have care and support need and their carers a legal right to request an assessment before they turn

18. This is to help them to plan for the adult care and support services they may need. All information in regards to Adult Social Care can be found here:

https://www.northumberland.gov.uk/Care/Support/Care-support-for-adults.aspx#informationsheetsaboutcareandsupport

1.2 Aims of Transitions Planning

The purpose of transition planning is to ensure that:

- Each young person experiences smooth and timely support to prepare for adulthood so that they are supported to meet their outcomes appropriately;

- Each young person is involved in the process, contributes their views and wishes, and has as much choice as possible about the future outcomes they hope to achieve and how they will be supported in this;

- The parents or carers of each young person are involved in the process as partners, and have clear and early information about how the transition process works and what the options may be for the young person;

- Adult services receive sufficient advance notice of young people whose needs they will be responsible for meeting, so that planning can be undertaken in a timely way.

1.3. How to Approach Transition Planning

Four elements should underpin all transitions work with every young person.

These are:

- Involving each young person as fully as possible. The young person, in whatever way they can communicate and understand, should have a say in what is being discussed. This will mean taking a person centred approach to the planning process;

- Where appropriate Involving the parents (carers) from the start;

- Working in as joined up a way as is possible with all other agencies, departments and with the young person and their parents. This means working together so that, wherever possible, separate assessments and planning processes can be combined, run together, or at the least, cross-referenced;

- Having a sense of the "time line" relevant to each young person preparing for adulthood and to the agencies that will need to plan to meet their needs. Without this, work may not be well planned or start early enough.

2. Transition and Information Management

The timely and effective sharing of information regarding a young person's needs, choices and preferences is central to effectively managing the process of transition.

Each practitioner (and associated team) has responsibility for ensuring that consent to share information is received from young people / parents / carers.

2.1 Transition Database

The Transition Database is managed by the Children Service performance team who cross reference with adult services around those young people who have already been referred. The Transitions Database is required as many of the teams working with people in transition across both children's and adult services have their own separate electronic recording systems that are not integrated with each other. This helps services start to identify early those cases that potentially may require ongoing services post 18. More importantly, it then supports discussions to take place between teams/individuals from Children and adult services and start that information sharing in a more planned way.

2.2 Pre-referral stage - sharing information with adult services prior to a formal referral

A formal referral within health and social care services is usually classed as being a clear request for a specific practitioner or team to start to offer in-depth support to an individual (the person being referred). However, as the transition process tends to take place over a period of years it is very often important to start to share information with partners in adult services well before a full formal and comprehensive referral needs to be made. At the pre-referral stage, information should be shared with adult services within the formal Transition Planning Meeting forums for inclusion on the transitions tracker via:

- Individual team's lists / spreadsheet of Transition case data - (This method should be used for transferring information regarding multiple cases);
- Transition Information Sharing Form (ISFs)

2.3 Sharing information via individual team case lists and via individual case specific ISFs: Key points -

- Sharing information via team's transition case lists and /or via an ISF is not in itself a formal referral to adult services;
- Team's transition case lists and ISFs provide data to populate the Transition Database which in turn informs transition planning and the panel meeting;
- Children Services may need to forward updated case lists and ISFs to adult services at intervals throughout the transition process, as individual circumstances for young people change.

2.4 Referral stage - Formally referring young people to adult social care and health services

Children's Services are responsible for ensuring that Adult Services are provided with all the definitive, comprehensive and up-to-date information that they will require to support a person in transition. A formal CM1 would need to be completed and forwarded to Onecall@northumbria-healthcare.nhs.uk.

2.5 Referring and Sharing health documentation and assessments at transition

The relevant health related documentation that should be shared with adult services for transition cases may take numerous forms and can relate to a wide range of health related needs, for example:

- General records of health:
    - GP's / Dentist's / Sensory (Sight and Hearing practitioner) details.
- Mental Health / Behavioural/ Emotional:
    - Psychological formulation/assessment;
    - Psychiatric report;
    - CPA records/related care plans.
- Behavioural assessments:
    - Behaviour Support Plans;
    - Functional Analysis.
- Risk assessments (depending on area of need):
    - Forensic Issues / assessments.
- Physical health needs / Support plans / Guidelines relating to:

- Epilepsy;
- Physiotherapy / Moving and Handling;
- Occupational Therapy;
- Speech and Language;
- Sensory Impairment
- Communication;
- Eating and Drinking Guidelines.

- Health Action Plan (Learning Disability specific);
- Continuing Health Care (CHC) assessment.

3. Eligibility Criteria for Adult Services - (Health and Social Services)

Practitioners must recognise that there are different eligibility criteria between children's and adult services. This means that a young person who receives support from Children Services may not automatically be deemed eligible to receive similar support from adult services. The initial question for Children Services must therefore be - 'is the young person eligible for an adult service(s)?'

In all cases it is good practice for a young person's eligibility for adult services to have been firmly established as soon as possible within the person's 16th year of age and no later than 17 and 6 months, depending on level and complexity of need and planning required (see Appendix 1). It should not been seen as the duty of the service that a person in transition is being referred to (unless specifically the remit of the team) to carry out in-depth clinical 'diagnostic' assessments.

If a young person is not eligible for Adult Health and Social Care appropriate actions will be identified within the transition planning meeting forums in order that any services needed to support a young person/adult are identified early enough to ensure smooth transition.

The Mental Capacity Act (2005) is an important piece of legislation that also needs to be considered. The Act provides a statutory framework for people from the age of 16 years old who lack capacity to make decisions for themselves, or have capacity and want to prepare for a time when they may lack capacity in the future. The five statutory principles of the act should be followed to protect and maximise individuals' abilities to make decisions.

4.1 Transition Meeting Forums

The process of 'transition' tends to take place within a wide operational and policy context across both Children's and Adult's health, social and educational services.

Due to the broad scope of transition there are a relatively large number of key stakeholders. To manage the range of transition processes a number of key meeting forums are required. These are:

- Transitions Planning Meeting - Quarterly
- Transition advice clinics with adult social care staff – as demand requires
- Individual case transition meetings - as and when required.

The roles and functions of these meetings are briefly discussed below.

4.2 Transitions Planning Meeting

The Transition Planning Meeting is a meeting which is chaired by Adult Social Care Senior/Operation Managers and takes place between Team Manager/key workers in Children Social Care/Early Help Services and Northumberland Adolescent Services. The panel will discuss any young person who has been identified as potentially requiring Adult Social Care intervention post 18 years. It is important that referral to the planning meeting is discussed with the young person, families or carers prior to the meeting to ensure that the key workers understands the views and aspirations of the young person involved and then any actions identified fed back to ensure they are aware.

At this meeting it will be agreed whether or not Adult Social Care would be required and at that point a more formal referral will be made by Children Social Care/Key Worker and Adult Social Care will allocate the case to the most appropriate team/worker/pathway based upon the identified needs of the Young person.

Issues for Consideration at the Transitions Planning Meeting

This is not a comprehensive list but it includes issues which may be usefully discussed and agreed:

-Roles and responsibilities clarified between workers e.g. attendance at school reviews; EHCP inputs etc

-Is joint work on assessment and planning needed? Joint work may be required if decisions need to be made now for children's services which will impact on planning and funding post 18;

-Role of other agencies clarified and any areas of work appropriate for other agencies;

-Identification of those young people who may meet Continuing Health Care Criteria in order to clarify potential Health contribution to the package; existing CCC or potential CHC status

-Identification of any actions, with attached timescales and review as required

-Identification of future provision/commissioning arrangements

-Signposting if Adult Social Care is not deemed as necessary. This will include service identification and any referrals to be made in a timely manner to support transition to adulthood

4.3 Transition Meetings for Individual cases - (Operational)

Depending on the level and complexity of a young person's needs, meetings between adult and children's services practitioners regarding individual cases are often required as a matter of good practice once a decision has been made at the Transitions Panel. This can be for a broad range of reasons. For example:

- To identify possible barriers and risks to a young person's transition;
- To consider the most appropriate adult team(s) to support the young person;
- To address questions relating to the 'eligibility' of a young person for various teams or services;
- To support a multi-disciplinary assessment of a person's transition needs covering the 4 PFA outcomes;
- To clarify, delegate and share duties between relevant practitioners in relation to a young person's transition;
- To monitor, manage and review a young person's transition plan.

Where a young person has been accessing residential care services, (i.e. a children's home provision, residential special school or Independent Supported Living (ISL) arrangement), prior to reaching the age of 18 then a conversation will take place between the Children's Commissioning Team and the Adults Commissioning Team. The aim is to improve communication between ensuring that any changes to the young person's needs assessment and therefore service provision are considered at an early stage and reflected appropriately within contractual arrangements. This will support providers in working with the young person to achieve a smooth transition.

5. Information and Duties for Practitioners

5.1 Initial guidance on the role of all relevant Children Services practitioners involved in supporting young people at transition

Practitioners from children's services should be consciously and proactively helping to prepare young people from the ages of 14 upwards and their parent / carer(s) for PFA and the changes that can occur throughout transition to adult services.

5.2 Managing expectations

There are various differences between the nature and type of services and indeed the legal and policy frameworks between children's and adult services. With this in mind, when working with young people and their parent / carer(s) it is important for Children Services practitioners to be considerate of the fact that it is not possible to guarantee that a young person will continue to receive the same level, type or amount of support in adult services that they received under children's services.

6 Transfer of Responsibilities from the Children's Social Care Team to the Adult Social Care Team

6.1 When does Children's Social Care Responsibility end?

Young people become adults on their 18th birthday and in most cases children's social care services cease to have any responsibility for young people as soon as they reach 18. This means that the children's services social work role ends and all funding and services end. There are two exceptions to this general rule:

Where a young person qualifies for advice and guidance in line with the Children (Leaving Care) Act 2000. The local authority has a duty to appoint a Personal Advisor (PA) to support them. The Personal Advisor will act as the focal point to ensure that care leavers are provided with the right kind of personal support throughout their transition to adulthood and independent life. Care leavers should be able to rely on consistent support from their PA, who is the designated professional responsible for providing and/or coordinating the support that the young person needs. This includes taking responsibility for monitoring, reviewing and implementing the young person's Pathway Plan.

The Personal Adviser is seen as a 'function' rather than a specific person and the local authority should consider delegating it wholly or partially to the best person able to carry out the role out (see Part 3, Regulation 8 of The Care Leavers (England) Regulations 2010). There is no prescribed professional or occupational qualification determining which professional should carry out the PA function for any individual care leaver. However a PA should normally possess or be working towards a professional qualification.

When allocating a Personal Adviser to a young person, consideration must be given to the wishes of the young person and to issues of gender, race, religion, linguistics, disabilities and equal opportunities. Where a young person has an identified transitions pathway in to Adult Services consideration should be given for that identified worker within Adult Services to assume the role of the PA from 18 years old. The worker within adult services will take the lead on coordinating that young person's care and support plan which will also act as the pathway plan from 18 years of age and link in with the leaving care team as and when required.

Where a young person is deemed no longer eligible for Adult Services and is aged between 18-25 years then Adult Services must make contact with the 18+ Team to ensure the continued offer of leaving care advice and support is afforded to the young person. Where appropriate, the young person will be allocated a PA within the 18+ Team to assume responsibility for monitoring and reviewing the young person's pathway plan up until the young person turns 25 if needed.

Good transitions planning will involve joint working between children's and adults social care in a planned way sometime before their 18th birthday. If the young person is at school, they may continue to receive education until the end of the academic year of their 19th birthday, as long as this continues to meet their needs. In these instances, the social work role and all other social care services and responsibilities transfer to adult services at the 18th birthday.

6.2 Acceptance of responsibility by Adult Social Care

There is no "automatic" transfer into the Adult Social Care teams. In order to achieve a smooth and well planned transition for each young person, it is essential for the Children's Social Work teams to alert the Transitions Panel to young people who may need Adult Social Care services, when those young people are 14 onwards. Funding issues must also be highlighted at an early stage. The proper processes for gaining agreement to funding from Adult Services must be adhered to, so there is time for the necessary planning to take place.

6.3 Changes to benefits concerning young people in transition

From the age of 16 it is sensible to advise young people and their parent / carer(s) to seek expert guidance on the changes to their benefits that can occur throughout transition. Either the Children's Services worker or the adult services care manager/social worker picking them up can seek support from a Welfare Rights Officer by ringing 01670 629590 or emailing welfare.rights@northumbria.nhs.uk.

6.4 Continuing Healthcare - Transition from child to adult services

Legislation and the respective responsibilities of the NHS, social care and other services are different in child and adult services. For children and young people,

from birth to 18 (i.e. their 18th birthday), needs are assessed against a children's national framework, with a recommendation made to a multi-agency panel. The term 'continuing care' has different meanings in child and adult services. For children and young people, continuing care refers to additional health support to that which is routinely available from GP practices, hospitals or in the community, and it can include care jointly commissioned by a local authority and CCG.

Children's services should identify those young people for whom it is likely that adult NHS Continuing Healthcare will be necessary, and should notify whichever CCG will have responsibility for them as adults. This should occur when a young person reaches the age of 14.This should be followed up by a formal referral for screening to the adult NHS Continuing Healthcare team at the relevant CCG, when the child or young person is 16. As soon as practicable after the young person's 17th birthday, eligibility for adult NHS Continuing Healthcare should be determined in principle by the relevant CCG, so that, wherever applicable, effective packages of care can be commissioned in time for the individual's 18th birthday. In order to do this staff from adult services (who are familiar with the adult NHS Continuing Healthcare National Framework) will need to be involved in both the assessment and care planning to ensure smooth transition to adult services.

7 Transport

7.1 Please visit below to find out information in relation to transport for Northumberland pupils for both pre and post 16.

https://www.northumberland.gov.uk/Education/Schools/School-transport-1/Transport.aspx

8 Northumberland Transition Safeguarding Policy

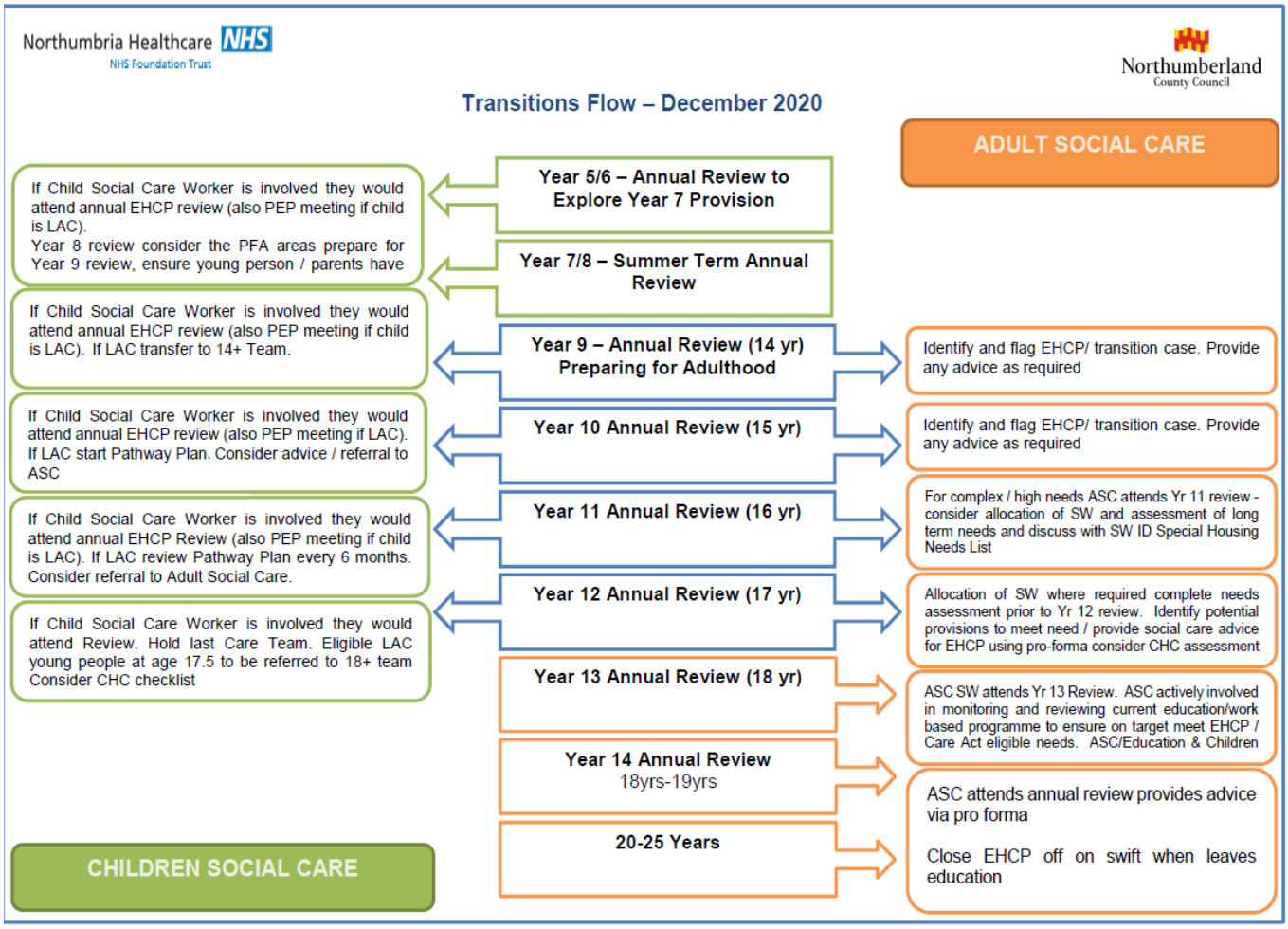
8.1 The Northumberland Transitional Safeguarding Protocol sets out the arrangements for young people aged 17.5 years and above, whose circumstances may mean that Safeguarding Adults procedures would apply when they are 18. This would be young people who would meet the definition of an 'adult at risk' when they turn 18.

The aim of the protocol is to promote robust transitional arrangements, and ensure effective and timely referrals between Children's and Adult Services in Northumberland. It recognises that harm is likely to continue post 18, and that abusers target vulnerability irrespective of age.

https://www.northumberland.gov.uk/Care/Support/Safeguarding.aspx

Appendix 1

Standard Operating Procedure


Northumbria Healthcare NHS
NHS Foundation Trust
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Transitions Flow – December 2020
ADULT SOCIAL CARE
If Child Social Care Worker is involved they would attend annual EHCP review (also PEP meeting if child is LAC).
Year 8 review consider the PFA areas prepare for Year 9 review, ensure young person / parents have
Year 5/6 – Annual Review to Explore Year 7 Provision
Year 7/8 – Summer Term Annual Review
If Child Social Care Worker is involved they would attend annual EHCP review (also PEP meeting if child is LAC). If LAC transfer to 14+ Team.
Year 9 – Annual Review (14 yr) Preparing for Adulthood
Identify and flag EHCP/ transition case. Provide any advice as required
If Child Social Care Worker is involved they would attend annual EHCP review (also PEP meeting if LAC). If LAC start Pathway Plan. Consider advice / referral to ASC
Year 10 Annual Review (15 yr)
Identify and flag EHCP/ transition case. Provide any advice as required
If Child Social Care Worker is involved they would attend annual EHCP Review (also PEP meeting if child is LAC). If LAC review Pathway Plan every 6 months. Consider referral to Adult Social Care.
Year 11 Annual Review (16 yr)
For complex / high needs ASC attends Yr 11 review - consider allocation of SW and assessment of long term needs and discuss with SW ID Special Housing Needs List
If Child Social Care Worker is involved they would attend Review. Hold last Care Team. Eligible LAC young people at age 17.5 to be referred to 18+ team Consider CHC checklist
Year 12 Annual Review (17 yr)
Allocation of SW where required complete needs assessment prior to Yr 12 review. Identify potential provisions to meet need / provide social care advice for EHCP using pro-forma consider CHC assessment
Year 13 Annual Review (18 yr)
ASC SW attends Yr 13 Review. ASC actively involved in monitoring and reviewing current education/work based programme to ensure on target meet EHCP / Care Act eligible needs. ASC/Education & Children
Year 14 Annual Review
18yrs-19yrs
ASC attends annual review provides advice via pro forma
20-25 Years
Close EHCP off on swift when leaves education
CHILDREN SOCIAL CARE