Warwickshire County Council

Preparing for Adulthood: Transitions Protocol from Children's to Adult Social Care

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Contents

1. Introduction

1.1 Warwickshire County Council adult social care and children's services are committed to providing a clear and timely transition from children's services to adult services for those young people who have continuing support needs.

1.2 This protocol aims to develop a successful, strength's based, outcomes led transition process for all young people aged 14 to 25 living in Warwickshire with additional needs, their families and carers, and for those currently living out of the county.

1.3 This transition protocol covers disabled young people aged 14 to 25 including those with:

- Learning disabilities;
- Physical disabilities;
- Sensory impairments (people who have hearing or sight disabilities);
- Complex health needs;
- Mental health disorder/illness or mental health problems in conjunction with the above.
- Autism.

1.4 Transition from childhood to adulthood is a challenging time and careful planning is essential to help young people make decisions about their future, to include options such as continuing their education and training, gaining work experience and paid or unpaid employment, finding suitable accommodation, promoting their health and well-being, participating in meaningful social activities and building effective relationships.

Having access to timely information, advice and guidance will help young people achieve their goals and aspirations in living the life they want to live and to become active members of their community. Transition planning will include giving the appropriate level of support to achieve the preparation for adulthood outcomes:

- Employment
- Independent living
- Community inclusion
- Health and well-being

1.5 For disabled and vulnerable young people and those with special educational needs, more support may be required during transition from a range of services to enable individuals to reach their full potential. It is essential for

children's services and education, adult social care and health partners to work effectively together throughout the transition process.

1.6 This protocol describes the agreed process for transferring case responsibility for young people with disabilities from the **children's social care services to the adult social care services**. For the purposes of this protocol 'young people with disabilities' are those who meet the Care Act 2014 eligibility criteria.

1.7 Whilst this protocol focuses on the transition in social care, this transition does not take place in isolation from other changes in the young person's life. As such, this protocol also sets out key events and expectations delivered by education and health services. Quality standards for transitions between children's and adult health services were published by NICE (December 2016).

1.8 This protocol is intended specifically for those involved in the social care transition, but will be of benefit to everyone involved in transition planning and anyone who has a duty or responsibility to ensure that young people with disabilities, their families and carers have access to the information, support and opportunities needed to make a successful transition to adulthood.

2. Key fundamentals of effective transitions

- There is a commitment by professionals across social care, education and health to empower young people and families by providing accessible information and advice to enable and support young people to live independently and achieve their desired outcomes.

- That young people and their families are listened to and are fully involved throughout the transition process. There should be a co-ordinated person-centred approach with young people and their families and personalised budgets should be promoted to increase choice and control.

- To enable young people and their families to learn, work and live safely in their own homes and communities by accessing locally-based services and opportunities.

- To avoid unnecessary placements in residential care and/or independent specialist provision that occur as a result of poor transition

- Identify young people with acute/severe/complex needs to ensure that high quality specialist provision is commissioned.

- Ensure that the experiences of young people and their families inform commissioning and the development of the provider market, local services and community developments, to prevent, postpone and minimise people's need for statutory support.

3. Legislation

3.1 The Children and Families Act focuses on putting children and young people at the heart of planning and decision making through co-production and person centred practice. It emphasises the importance of engaging young people and their families in all processes from developing and planning, particularly in relation to the local offer and Education, Health and Care Plans (EHCPs), and also in the commissioning of services and strategic decision making.

3.2 In alignment with this, the **Care Act** focuses on individual wellbeing with an emphasis on outcomes and person-centred practice. For the first time, participation in **work** has been identified as an outcome for adults with care and support needs. This development should ensure that the focus on young people having **employment** as they move into adulthood is maintained by adult social care.

3.3 Some young people will be subject to other legislation such as the Mental Health Act 1983/2007 and may require section 117 aftercare. The Mental Capacity Act 2005 will apply to young people who lack capacity, and applications to the Court of Protection may be made in relevant circumstances with regard to the Deprivation of Liberty Safeguards.

3.4 The Care Act introduces a new duty on local authorities to carry out **Child's Needs Assessments (CNA)** for young people who are likely to have needs for care and support after they reach 18. Young people or their parents can request a CNA at any time prior to a young person's 18th birthday whether or not they have an EHC plan. The purpose of a CNA is to determine what adult social care a young person might be eligible for once they reach 18, so they can make informed choices about their future.

3.5 The local authority can decide not to carry out an assessment where there is not "likely to be a need for care and support post 18or because the timing is not of "significant benefit" to the young person's preparation for adulthood.

3.6 The rules on NHS Continuing Healthcare funding (CHC) come into force at

age 18 and some young people with EHC plans will need to be assessed for eligibility. Young people eligible for NHS CHC have the right to request a personal health budget in most circumstances.

3.7 Packages of care are likely to change as a young person moves from children's to adult services. At the age of 18, young people open to children's social care, following assessment and confirmed eligibility for support from adult services, transfer to and become the responsibility of adult services. From that point their care needs and resultant care package will have been identified by a 'Needs Assessment' and by the use of the Adult 'Resource Allocation System' (RAS). It is important to note that due to the differing legal requirements on the local authority, the changed nature of the relationship between the (former) young person, now adult, and the local authority and the differing market for the provision of services to adults, that the financial size of any care package to meet needs, may change (positively or negatively) at the point of transition. It is possible that within mental health services, the young person may be entitled to aftercare services under section 117 of the Mental Health Act 1983/2007.

4. Assessment and planning through transition – the overall approach

4.1 From year 9 onwards, review meetings (in particular the EHC plan review) should support the young person and their family to plan for the future by providing them with information about what they can expect. This should be reflected in the single assessment care plan and EHC plan. Plans should increasingly focus on the four preparation for adulthood outcomes.

4.2 For young people likely to require adult social care, the children's social care allocated worker will have lead responsibility to ensure this is incorporated into the single assessment plan or care/pathway plan if they are children looked after up until the age of 18.

4.3 Before a young person's 18th birthday, the Transitions Team will work with the young person and their allocated children's worker to confirm likely needs beyond the age of 18 and identify those which will be eligible for social care and support. The Transitions Team will then co-produce a care and support plan ready for when the young person turns 18.

4.4 Some young people aged 16-17 who are not currently supported by children's social care, may have needs for social care after the age of 18 and may benefit from an assessment. These young people may be identified by SENCOs, head teachers and may present to the Customer Service Centre. In these circumstances, a referral will be made to the appropriate team

(children's social care or adult social care) to complete an assessment.

4.5 Transitioning into adult mental health services should begin before the young person reaches 18, the age at which they will be accepted into adult mental health services. This process is outlined in a separate mental health transitions process document in Appendix 1.

4.6 Professionals should be mindful that transition to adult services has significant financial implications for young people and their families. The financial assessment in social care may require a contribution to the cost of care. In addition, there are changes to social security benefits and how these are assessed. Young people and families should be signposted to the appropriate information, advice and support, such as the Citizen's Advice Bureau to assist with these changes.

4.7 Key transition events across social care, education and health are set out in the table below.

Age	Social Care	Education (assuming young person has EHC plan)	Health (assuming young person has health plan)
	Young person supported to achieve the outcomes as set out in the Care Plan with regular review	Young person supported to achieve the outcomes set out in the EHC Plan	Young person supported to achieve the outcomes as set out in the healthcare plan(s) with regular review
Age 14	Signposted to information about entitlements	School should provide impartial careers guidance	Initial conversation and planning for adult health services
	School organises annual EHC Plan reviews which should include initial discussions about future outcomes of employment, independent living, community inclusion and health and wellbeing. The voice of the young person should be central to this review.		
Age 15		Work experience is often arranged in Year 10.	
	School organises annual EHC Plan reviews which should include more detailed discussions about future outcomes of employment, independent living, community inclusion and health and wellbeing.		
Age 16	SEND Social Care / children's social care and safeguarding maintain responsibility but notify Adult Social Care Transition Team of young people that are likely to need adult social care at the age of 18. Adult Social Care Transition Team to assign worker to joint work with children's worker to start transition planning and adult social care assessment and attend annual EHC Plan review, and any other reviews.	EHC Plan outcomes to be focussed on preparation for adulthood Young person may consider a move to further education at school year 12; supported placements must be agreed through EHC plan	It is advisable to ensure that the GP is involved in transition planning at this point. Continuing Care team to identify and notify Continuing Health Care of any young people likely to require support beyond the age of 18. Transition between health services begins in accordance with NICE guidance
	School/college organises annual EHC Plan review.		
Age 17	Signposted to information about entitlements and how they change at 18 More detailed discussions about housing and independent living Before the 18th birthday, the Adult Social Care Transition Team carries out the adult social care assessment and financial assessment. The Care and Support Plan should be agreed.	SENDAR can provide impartial careers advice to young people with SEND	Before the 18th birthday, the Continuing Health Care (if applicable) carries out the health assessment. The Health Care Plan should be agreed.
	School/college organises annual EHC Plan review		
18th birthday	At 18, the worker from the adult social care transitions team take on full responsibility and become the young person's allocated worker		At 18, the GP becomes the co-ordinator of care for health services
Age 19 up to 25	Adult Social Care Transitions Team transfers young person to adult community teams following successful transition	Young person may consider a move to further education at post special school (subject to support being confirmed on the EHC plan)	
	School/college organises annual EHC Plan review.		

5. Compliments and complaints

5.1 Any compliments or complaints on the experience of transition from SEND social care to adult social care can be submitted to Warwickshire County Council via the website at: https://www.warwickshire.gov.uk/contactus

5.2 Feedback and complaints about NHS care, treatment or services should be made in accordance with the procedure set out on NHS Choices website.

6. Further information and review

6.1 Further information on SEND can be found at https://www.warwickshire.gov.uk/send

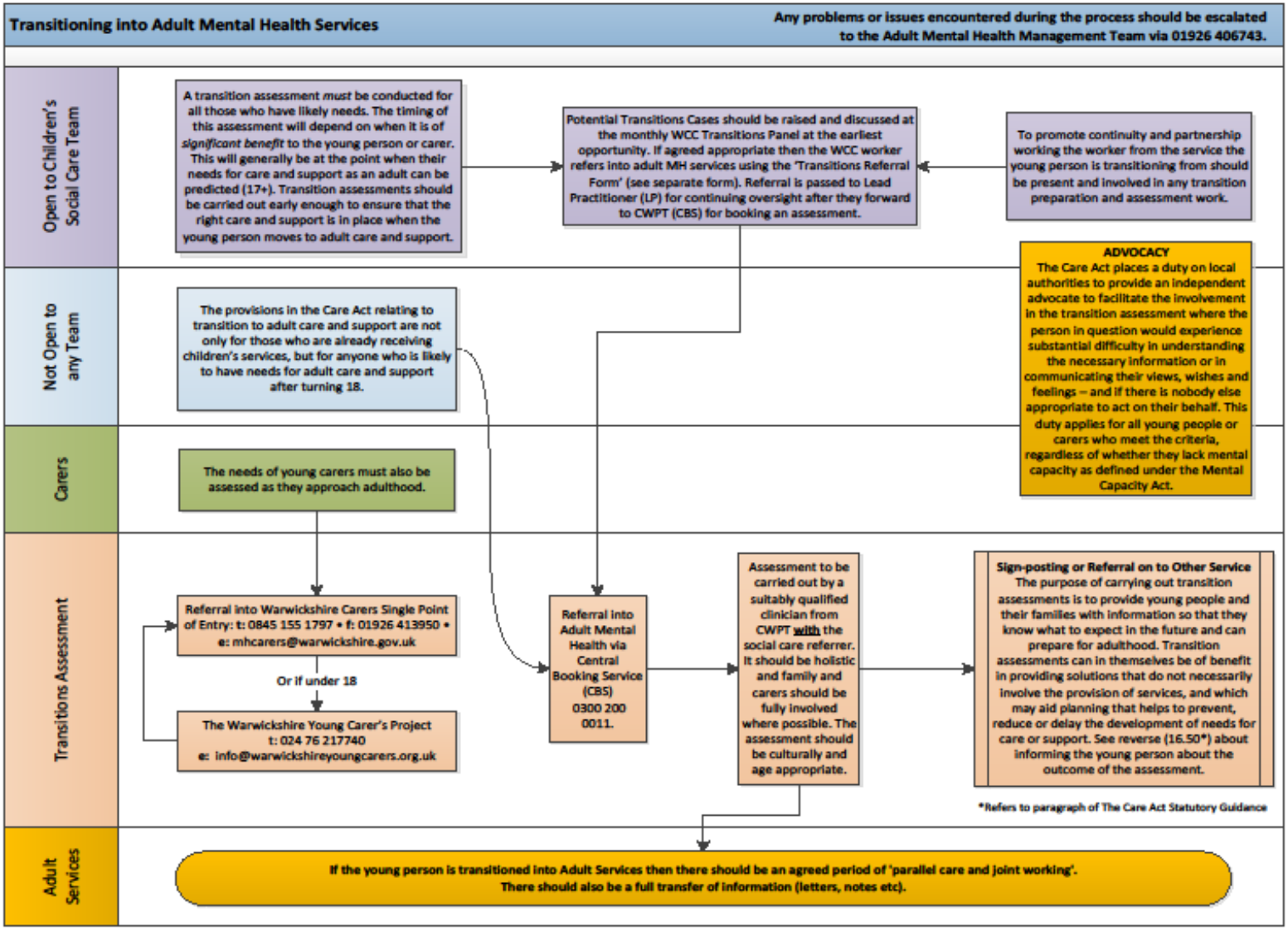
6.2 This protocol will be reviewed by the Service and Operational Managers for Adult Disabilities.

7. Glossary

Source: www.thinklocalactpersonal.org.uk/

Term	Definition
Adult social care	**Care and support for adults who need extra help to manage their lives and be independent** - including older people, people with a disability or long-term illness, people with mental health problems, and carers. Adult social care includes assessment of your needs, provision of services or allocation of funds to enable you to purchase your own care and support. It includes residential care, home care, personal assistants, day services, the provision of aids and adaptations and personal budgets.
Assessment	**The process of working out what your needs are.** A community care assessment looks at how you are managing everyday activities such as looking after yourself, household tasks and getting out and about. You are entitled to an assessment if you have social care needs, and your views are central to this process.
Assistive Technology	**Equipment that helps you carry out daily activities and manage more easily and safely in your own home.** Examples include electronic medicine dispensers, memory prompts, 'big button' telephones or remote controls, and pendant alarms for wearing around your neck or wrist. It also includes equipment that can detect potential hazards in your home, such as a fire or flood, or that can alert a carer or the emergency services in the event of a fall or seizure.
Autism spectrum disorder	**A condition that someone is born with that affects their ability to communicate and interact with the world around them**. It is also called autism, and covers a wide range of symptoms. It affects people in different ways, and some individuals need much more help and support than others.
Care Plan	**A written plan after you have had an assessment, setting out what your care and support needs are, how they will be met (including what you or anyone who cares for you will do) and what services you will receive.** You should have the opportunity to be fully involved in the plan and to say what your own priorities are. If you are in a care home or attend a day service, the plan for your daily care may also be called a care plan.
Commissioning	**The process of planning services for a group of people who live in a particular area**. It does not always mean paying for services, but making sure that the services people need are available in that area.
Complex needs	**You may have complex needs if you require a high level of support with many aspects of your daily life and rely on a range of health and social care services.** This may be because of illness, disability or loss of sight or hearing - or a combination of these. Complex needs may be present from birth, or may develop following illness or injury or as people get older.
Continuing Health Care (CHC)	**Ongoing care outside hospital for someone who is ill or disabled, arranged and funded by the NHS.** This type of care can be provided anywhere, and can include the full cost of a place in a nursing home. It is provided when your need for day to day support is mostly due to your need for health care, rather than social care. The Government has issued guidance to the NHS on how people should be assessed for continuing health care, and who is entitled to receive it.
Deprivation of Liberty safeguards	**Legal protection for people in hospitals or care homes who are unable to make decisions about their own care and support, property or finances**. People with mental health conditions, including dementia, may not be allowed to make decisions for themselves, if this is deemed to be in their best interests. The safeguards exist to make sure that people do not lose the right to make their own decisions for the wrong reasons.
Education, Health and Care Plan	**A legal document for a child or young person up to the age of 25 if they have a disability or special educational needs (SEN).** It describes the child or young person's particular educational, health and social needs, and sets out the support and extra help they should have to meet those needs, and how this will support them to achieve what they want in their life.
Personal budget	**Money that is allocated to you by your local council to pay for care or support to meet your assessed needs.** The money comes solely from adult social care. You can take your personal budget as a **direct payment**, or choose to leave the council to arrange services (sometimes known as a **managed budget**) - or a combination of the two.
Personalisation	**A way of thinking about care and support services that puts you at the centre of the process of working out what your needs are, choosing what support you need and having control over your life.** It is about you as an individual, not about groups of people whose needs are assumed to be similar, or about the needs of organisations.
Transition	**The process by which young people with health or social care needs move from children's services to adult services**. It should be carefully planned, so that there are no gaps in the care young people receive. Young people and their families should be fully involved in the planning process.

Appendix 1 – Mental Health Transition Pathways



Information for referral to Adult Mental Health Services

- Name, address, contact numbers, NOK contact numbers, GP name and address
- Has the person consented to the referral? Do they want help?
- Is there evidence that this person poses a risk to either themselves or others? Incidents of aggression?
- Has the person self-harmed in the past or made previous suicide attempts?
- Are there any safeguarding concerns – adults or children?
- Is this person being exploited or have a history of being exploited?
- Do they have a carer or support network?
- Are there any protective factors? E.g friends, carers
- Is there a history of mental health difficulties / contact with services? If so, what?
- Are they experiencing low or high mood?
- Has this person experienced a traumatic event recently or in the past?
- Is there any evidence of anxiety?
- Mental health difficulties associated with pregnancy or birth?
- Does this person appear to have psychotic symptoms? E.g. Hearing voices, seeing things others don't, delusions etc
- Are there any symptoms of an eating disorder?
- Is the person experiencing any problems with memory?
- Are they confused or disorientated?
- How do their mental health difficulties impact on their everyday functioning?
- Do they have a criminal record?
- Does the person use illicit substances or have they in the past?
- Does the person misuse alcohol?
- Do they have any other care and support needs (Care Act)
- Other factors to consider such as animals at home, two-person visits, will gender of assessing clinician matter?

This guidance should be read before completing the Mental Health Transitions Referral Form.

Transitions Assessments

- Effective person-centred transition planning is essential to help young people and their families prepare for adulthood. Transition to adult care and support comes at a time when a lot of change can take place in a young person's life (16.1*)
- The transition assessment should support the young person and their family to plan for the future, by providing them with information about what they can expect. (16.24*).
- Having carried out a transition assessment, the local authority must give an indication of which needs are likely to be eligible needs (and which are not likely to be eligible) once the young person in question turns 18, to ensure that the young person or carer understands the care and support they are likely to receive and can plan accordingly (16.50*).
- Features of a transition assessments must include an assessment of:
    - current needs for care and support and how these impact on wellbeing;
    - whether the child or carer is likely to have needs for care and support after the child in question becomes 18;
    - if so, what those needs are likely to be, and which are likely to be eligible needs;
    - the outcomes the young person or carer wishes to achieve in day-to-day life and how care and support (and other matters) can contribute to achieving them.
- Transition assessments for young carers or adult carers must also specifically consider whether the carer:
    - is able to care now and after the child in question turns 18;
    - is willing to care now and will continue to after 18;
    - works or wishes to do so;
    - is or wishes to participate in education, training or recreation.

*Refers to paragraph of The Care Act Statutory Guidance