Southampton City Transition to Adulthood

Practice guidance

SOUTHAMPTON CITY COUNCIL

NHS
Southampton City
Clinical Commissioning Group

Contents

1. Introduction

1.1 Overview

Approaching adulthood can be a time of apprehension and confusion for young people. It can feel like there are many things to consider, plan for and make decisions about and this can often feel overwhelming, particularly when there are additional needs presenting in a young person's life. There may be long term health conditions, learning disability, families receiving social care support and other needs that mean a young person will need additional support and planning to support their move from childhood to adulthood.

This Practice Guide will look at how services should work together to identify and plan for the eventual transfer into Adult Services. It will cover all children who require some sort of transition planning working towards ensuring that the young person is as ready and prepared as they can be to enter this next stage of life.

The purpose of this Practice Guide is to provide information which will detail the process of transition, how it should happen and who should be involved. It will aim to ensure that young people and their families / carers experience a positive transition, ensuring early identification of young people who need additional support, joint working, and clarity of available service provision. All services working together will ensure that young people and their families are supported to make decisions that are right for them and to ensure that they go onto live as full a life as possible.

The Practice Guide covers all children and young people (CYP) under the age of 18 who require transition planning into adulthood.

Transition is defined as:

> "A purposeful, planned process to firstly prepare young people moving from a child-centred to adult-orientated service and secondly address the medical, psychological and educational/vocational needs of adolescents and young adults as they move from child-centred to adult-orientated health care systems."

Adapted from Department of Health (DOH) definition, 2006.

1.2 Outcomes

In defining outcomes for "good transition", we have adopted the four domains outlined in the Special Educational Needs and Disability (SEND) Code of Practice and subsequent best practice guidance for preparing for adulthood published by the national Preparing for Adulthood programme (PfA) delivered by the National Development Team for inclusion (NDTi) and funded by the DfE. These relate to young people's achievement and maintenance of

- Good Health.
- Employment (also including further/higher education and training).
- Independent Living.
- Friends, relationships and community inclusion

1.3 Who is Transition for?

This guide is for the transition to adulthood of any young person with additional needs for whom a planned transition is required.

This will include (but is not limited to):

- Young people with SEND (with or without an Education, Health and Care Plan).*
- Young people with Mental Health problems.

- Looked After Children/Care Leavers.
- Young People in the Youth Justice System.

In Southampton, the needs of children and young people with SEND have been defined in terms of a needs based criteria as follows:

- **Low** - needs that can be met through universal services and network of family and friends.
- **Medium** - additional needs which may require additional support above what is available at the universal level, e.g. additional advice and support, benefits, adapted or targeted services and activities.
- **Substantial** - needs that significantly impact on a young person's ability to function requiring targeted or specialised services
- **Complex** - severe needs which significantly affect everyday life and require specialist support.

*Young People with SEND

2. Policy, Law and Guidance

This document has been informed by relevant legislation and guidance around transition. The legislation places statutory responsibilities on the Local Authority, Health and Education to ensure that children and young people who need transition planning receive it.

2.1 The Children and Families Act 2014

The Children and Families Act 2014 introduced greater protection for vulnerable children, improved support for children whose parents separate, a new system to help children with SEND and help for parents to balance work and family life. Part 3 of this act lays out the duties of local authorities, health and education to provide for those with SEND up to the age of 25. Detail of the Act can be found in the link below.

www.legislation.gov.uk/ukpga/2014/6/contents/enacted

2.2 SEND Code of Practice

The SEND Code of Practice (section 3 of the Children and Families Act 2014) details what duties Local Authorities, Health and Education organisations must provide regarding children with Special Educational Needs and Disability. The Code introduces a system of support from 0-25 years of age through coordinated assessment and Education, Health and Care Plans (EHCPs), stipulating the importance of joint working between Health, Social Care and Education and integration between these organisations when this is in the best interest of the child. It highlights reforms such as the joint development of a Local Offer, the development of Personal Budgets and engagement with Parent/Carers and Young People. It is within the code that duties placed on Local Authorities and Health are detailed in full. Details of the code can be found in the link below. Chapter 8 highlights the importance of transition from the earliest years with specific focus required from year 9 upwards.

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/398815/SEND_Code_of_Practice_January_2015.pdf

2.3 The Care Act 2014

The Care Act is formed from the themes of various different acts into a single piece of legislation which puts the individual wellbeing for adults with care and support needs over the age of 18 as a priority. There is a particular focus on person centred outcomes and giving more power to individuals to be in control of their care and support. Details of the act can be found in the link below.

www.legislation.gov.uk/ukpga/2014/23/contents

2.4 NICE Guidelines for Transition

The NICE Guidelines were published in 2016, two years after the Children and Families Act 2014 came into force. The guidance not only includes the health elements of transition planning, but also joins it up with social care ensuring that services work together to plan and jointly commissioning services for those young people entering into adulthood. Details of the guidance can be found in the link below.

www.nice.org.uk/guidance/ng43

2.5 The Mental Capacity Act 2005

The rights of young people to make a decision is subject to their capacity to do so as set out in the Mental Capacity Act 2005. The five key principles of the act are:

- Always assume a person has capacity unless it is proved otherwise.
- Must take all practicable steps to enable people to make their own decisions.
- Must not assume incapacity simply because someone makes an unwise decision.
- Always act, or decide, for a person without capacity in their best interests.
- Carefully consider actions to ensure the least restrictive option is taken.

Decisions about mental capacity are made on an individual basis, and may vary according to the nature of the decision. Someone who may lack capacity to make a decision in one area of their life may be able to do so in another. Details of The Act can be found in the link below.

www.legislation.gov.uk/ukpga/2005/9/contents

3. A Good Transition for All – The Universal Pathway

3.1 Overview

Regardless of which service the young person has come from in Children's Services or their specific type of need, the overall process and principles of good transition should be common to all. Hence a Universal Pathway (Appendix 1) has been designed to provide a plan on a page, laying out the key points of transition planning for both services and families, in each year leading up to 18 years of age and beyond. The Universal Pathway can be found in appendix 1, embedded below and is described in this section:

Appendix 1

3.2 Key Principles

In Southampton, local engagement with services and parent/carers have identified the following key principles which should be common to all transitions:

- Working closely with parents/carers and their young person and having honest conversations to support realistic expectations.
- Being clear about what services and support is available.
- Person Centred planning.
- Identification of a lead professional to coordinate a young person's transition.
- Effective early planning.
- Involving young people and their carers in service design.
- Good communication with young people, parents/carers and all professionals involved throughout the transition process.
- Accurate and up to date assessment of needs of young people and of carers.
- Ensuring transition is developmentally appropriate.

- Services working together (and joint commissioning).
- Focussing on outcomes as opposed to services and processes.

These key principles are further supported by the SEND Code of Practice which highlights that:

- The views, wishes and feelings of the child or young person and the child's parents should be taken into account throughout the transition process.
- The child or young person and the child's parents should be able to participate as fully as possible in decisions, and be provided with the information and support necessary to enable participation in those decisions.
- The child or young person and their parents/carers should be supported to facilitate the development of the child or young person and to help them achieve the best possible educational and other outcomes, preparing them effectively for adulthood.
- Where young people have EHC Plans, local authorities should consider the need to provide a full package of provision and support across education, health and care that covers five days a week, where that is appropriate to meet the young person's needs.

3.3 Key Steps in the Pathway

Stage One:

Commencement of Transition Planning (age 14-16 / Years 9-11)

The SEND Code of Practice stipulates that early consideration of transition planning should begin at age 14 (year 9) and this principle has been adopted in the Universal Pathway for any young person requiring a planned transition.

For children with SEND and an EHCP, this should be triggered at the academic Year 9 EHCP review meeting which is coordinated by the child's school.

For children who do not have an EHCP, this should be triggered at the most appropriate Annual Review between the ages of 14 and 16, for example the Pathways Review at age 16 if the young person is a care leaver, or the young person's CAMHS or Paediatrician review.

For children placed out of area, it is the responsibility of their Social Worker or (if they are in a special school) their SEND Officer to ensure that this happens.

For children subject to multiple statutory processes (e.g. they may have an EHCP and also be looked after, have continuing health care needs or be a child in need), every effort should be made to join up the various reviews and planning processes to ensure that these are coordinated and their transition is planned in a single meeting.

At this point in the transition pathway, professionals involved in the young person' s care, education and support should be starting to have meaningful conversations with each other, the young person and their parent/carer about the young person's future aspirations and needs and how these will be best met in adult services.

To support these discussions, **lead professional/s** within children's services should be identified (usually one from education and one from health/social care services) at this time to coordinate planning and ensure that there is good communication. The lead professional role is central to the Universal Transition Pathway and is described in more detail later in this Section.

A key part of the lead professional role is to pull together a **Transition Support Plan** setting out the young person's aspirations for adulthood, outcomes to be achieved, an up to date assessment of the young person's needs and the support they will require to meet them. The Transition Support Plan will also include an action plan setting out what needs to happen and by whom to ensure a smooth transition. It will also identify key contacts, including the names of the lead professionals in both children and adult services. The Transition Support Plan is central to the Universal Transition Pathway and is described in more detail later in this section.

At this point in the transition pathway, the lead professionals should also signpost the young person, their parents and carers to the Local Offer pages for Preparing for Adulthood which set out the services available within the city from a transition and adult service perspective. The lead professionals should also advise the young person and their parent/carers of their rights to advocacy and to a carer assessment and how to access these, again signposting as appropriate to the Local Offer.

Example of Good Practice - the use of the Ready Steady Go tool in acute hospital clinics (Diabetes, Epilepsy clinics)

Ready, Steady, Go is a tool used in a number of hospital clinics to support planning for transition to adult services. The tool is set in motion when the young person is aged 14 and has a number of key stages. Each stage has a series of questions and prompts that the clinician will work with the young person and their parent/carer to ensure they learn more about their condition and how it will impact them as they become an adult. Ready, Steady, Go covers knowledge of the condition, self- advocacy, health and lifestyle, daily living, school and future, leisure, managing emotions and transfer to adult care with each stage expanding those area's as the young person moves closer to the age of transfer. The templates can also be found via the following link:

www.uhs.nhs.uk/OurServices/Childhealth/TransitiontoadultcareReadySteadyGo/Transitiontoadultcare.aspx

Example of Good Practice - Transition Nurse Role in Jigsaw Service

The Jigsaw integrated health and social care team for children with SEND at the complex level has appointed a Transition Nurse Specialist to work alongside young people and their families to bridge the gap between children's and adult services by facilitating collaboration and communication between the different agencies involved with the young person's transition. The Transition Nurse Specialist is able to provide information about some of the changes young people and their families can expect as they move into adult services.

The Transition Nurse Specialist may also attend Annual EHCP Reviews in order to identify which young people are likely to require additional support during transition. This includes ensuring that ongoing health needs are identified and referrals are made to adult services or signposted to appropriate services. The nurse may suggest the completion of a Health Passport, Hospital Passport or Ready Steady Go documentation to ensure that the young person's needs are central to transition planning.

A referral to the Transition Operational Group (TOG) should be made before the February half term of year 11 (age 15/16) for those young people who have a particularly complex set of needs. Prior to referring to TOG, consent from the young person and parent/carer should be sought. The purpose of TOG is described in more detail later in this section.

Stage Two:

Referral to Adult Services (Age 17 ½ / School Year 12)

By the age of 17 ½ , formal referral will need to be made to Adult Services (e.g. Continuing Health Care, Adult Mental Health, Adult Social Care, Adult Learning Disability Team) to determine eligibility (although for complex cases, there should already have been a conversation at TOG as to the likelihood of meeting Adult Service criteria to enable alternative plans to be made for the young person as necessary).

It is at this stage that the Lead Professional for Adult Services should be identified so that the bridge can be formed to ensure a smooth handover between children services and adult services.

When a child has been under the care of children's health services and they are found not to be eligible for adult services, then contact with their GP should be initiated by the Children's Lead Professional (child health or children's social care, whichever is most relevant) in order to discuss their transition plan and how they will be supported in adulthood. In such incidences, the Transition Support Plan should be shared with the GP, following consent from the young person.

The lead professional will be responsible for overseeing the young person's transition support plan and ensuring actions to achieve smooth

Example of Good Practice -Transition Therapy Team

The Transition Therapy Team sits under Solent Adult Neurological Rehabilitation Services and works to support disabled young people to become empowered adults. The team works alongside young people and their family or carers to support growing independence, helping young people to feel more able to take the lead in their healthcare. By offering occupational therapy and physiotherapy input, the Therapy Transition Team supports with developing a wide range of skills and linking with other agencies to find opportunities for the future.

The service accepts young people, between the ages of 14-25 who have complex physical disabilities and who have a Southampton GP. These disabilities are predominantly neurological and some young people also have learning disabilities.

The team is based at the Western Community Hospital, but also meets young people in their homes, schools, colleges, university halls, work places and other community settings and accepts referrals from other health services, education, social care, advocacy and can also be self referral.

transition are continuously updated and delivered to timescale.

For those cases referred to TOG, there will be continuous review of the Transition Support Plan and progression of the case by TOG.

Stage Three:

Transition (Age 18 / School Year 13)

Most young people should have transitioned into adult services by Age 18 (year 13) and care should be formally handed over from Children to Adult Services. At this point, the lead professionals within children's services will have completed their role.

For those young people with an EHCP, their education needs will continue to be met through their EHCP until their education outcomes have been met or they are 25 years old (whichever is the soonest) and the Lead Professional from Education Services will continue to be involved, ensuring the young person feels more and more empowered and independent approaching 25. However, the responsibility for any wider health and social care needs will have transitioned to adult services as described above.

For care leavers, the Lead Professional from children's services (who is likely to be their Social Worker or Personal Advisor) will remain involved until they reach 21 years old. The responsibility for any wider health needs will have transitioned to Adult Health Services.

Example of Good Practice - Transition Support Clinics

For young people with a Long Term Health Condition there are a number of Transition Clinics that exist in Southampton, mainly running from UHS. For young people with Epilepsy the transition process begins at aged 13 and uses the Ready, Steady, Go (RSG) protocol. The 'Ready' appointment is triggered at 13 and usually involves an appointment with parents. This appointment is focused on the young person taking more ownership of the condition, being responsible for taking their own medication etc. At aged 15 'Steady' is triggered and the young person usually has the first 10 minutes of the appointment alone. Area's such as sexual health specific to the condition, medication and social issues are discussed. At age 16-17 'Go' is triggered and the young person and parent/carer attends the transition clinic. The Clinic includes an Adult Neurologist, Paediatric Neurologist and Adult Epilepsy Nurse Specialist. The Adult Neurologist see's all transition patients once and decides whether they will require further consultant led input into adulthood, or whether they can be referred back to their GP. If referred to a GP, there is no further access to the Adult Epilepsy Nurse Specialist, but they will have access to a Community Epilepsy Nurse Specialist. Within the transition clinic, elements such as medication, the medical elements of the condition are addressed, social/educational and aspirational areas are discussed i.e. What careers are realistic and what aren't. The clinic also looks at what additional support is required e.g. bus pass and certain risks and safety elements that need to be taken into consideration.

Other Transition Clinics exist for young people with Diabetes, with a Specialist Diabetes Transition Nurse focusing on young people aged 17-19. The nurse provides support, education, monitoring and help to the young person as they navigate their way from paediatric services into adult services with the final point of transfer being the Transition Clinic. The Transition Clinic is attended by paediatric and adult services, the parent/carer, the young person and the Specialist Diabetes Transition Nurse. This service uses the Ready, Steady, Go (RSG) protocol as well to ensure that transition has been planned in a timely and thorough way.

In order to support the universal pathway for good transition, a number of key elements have been introduced:

- Transition Operation Group (TOG) – specifically for young people with SEND at the complex level but will also take referrals for any other young person where there is concern about their transition
- Lead Professional Role
- Transition Support Plan

3.4 Transition Operational Group (TOG)

The Transition Operational Group (TOG) has been established to bring together a multi-agency group of service and operational leads from education, health and social care, to provide leadership on:

- Overseeing transition processes as a whole.
- Specifically overseeing and monitoring the transition of specific cases where a more focussed, managed multi-agency approach is required.
- Ensuring that adult services are kept up to date on young people who will be transitioning in the next 3-4 years, particularly those with complex needs to inform planning and budget setting.
- Identifying and recording gaps in services for planning and commissioning purposes.

All young people at the complex level of disability (i.e. known to Jigsaw or placed out of city) will automatically have their transition overseen by TOG. For young people at the substantial and medium levels of disability and other groups of young people (e.g. care leavers, young people in the youth justice system), professionals will have the opportunity to refer to TOG to oversee a transition if they feel that the transition is not progressing in a way that best supports the young person's outcomes. In all cases the responsibility for transition will remain with those children's and adult services in education, health and social care who are working with the young person. In order to ensure that this is clear, TOG will ensure that lead professional/s have been identified for all

cases referred to TOG.

Cases should be first alerted to TOG before the February half term of year 11 (age 15/16) and formally referred at age 17.5 for those young people who have a particularly complex set of needs.

For each case referred TOG will specifically:

- Ensure that the needs and wishes of the young person now and into the future are clearly documented and understood and that there is a clear plan in place to support their transition to adulthood (the Transition Support plan).
- Ensure that lead professional/s from both Children's Services and Adult Services are identified to oversee and monitor the Transition Plan. This should ideally be identified at the Year 9 Annual Review and certainly by the Year 11/12 Annual Review.
- Provide a screening, advice and signposting role where eligibility for assessment by adult services is not evidenced.
- Continuously review progress against the Transition Plan to ensure that it is progressing to plan and support the lead

professional/s with trouble-shooting any issues / blocks that arise.

- Ensure that the case is presented at TOG for financial resolution before the February half term of year 11 (age 15/16) if there is a need to agree any unusual funding request or if there is a funding dispute.

TOG meets monthly and regularly reports on progress to the SEND Partnership Forum, highlighting any gaps and issues.

Detailed TOR are attached at Appendix 2 and embedded below.

https://sid.southampton.gov.uk/mediamanager/southampton/directory/files/tog-terms-of-reference.pdf

3.5 Lead Professional Role

Every young person with additional needs requiring support to transition from children's to adult's services should have identified named lead professionals in children's services and adult services who will take responsibility for the coordination of care and support as the young person navigates out of children's services and into adult services.

The lead professionals will act as the point of contact for the young person, his/her family and other professionals involved in the care and support of the young person.

The lead professionals will co-ordinate the care and support for the young person, ensuring the development of a multi-agency transition plan, and monitoring the compliance with the plan of other professionals.

In children's services, there will usually be one or two (depending on the complexity of need) lead professionals. This will usually be the SENDCO or Head Teacher from the young person's school, if the young person has special educational needs, or possibly the Virtual School Head if the young person is looked after, and the health or social care professional most familiar with the young person if the young person has complex health and/or social care needs.

For young people with complex health needs, this could be the young person's community children's nurse, Jigsaw nurse, specialist nurse or CAMHS professional, depending on which service they fall under.

For young people with social care needs, this could be the Jigsaw Social Worker if they have SEND at the complex level, another Social Worker if they have SEND at the Substantial or Medium level , the Pathways Social Worker if they are a care leaver or a Youth Offending Team worker if they are in the Youth Justice System.

The Children's Services lead professional/s will usually be identified at the Annual Review between the ages of 14 and 16 (i.e. the Year 9 Annual Review if the young person has an EHCP, the Pathways Review at age 16 if the young person is a care leaver, or their CAMHS, CCN or Paediatrician review if the young person is not looked after or does not have an EHCP). At this point a Transition Support Plan will also be started in which the name of the lead professional/s will be recorded.

The lead professional/s in children's services will ensure referral to the appropriate adult service (if required) by the time the young person is 17 years

6 months and will link with the lead professional for adult services, to ensure a smooth transition.

The lead professional in adult services will come from the service into which the young person has been referred, e.g. Adult LD team, Adult MH team, Adult Social Care. Referral will usually take place at age 17 following which adult services will assess and, if the young person meets eligibility criteria, allocate a lead professional to work with children's services to facilitate transition. The name of the lead professional in adult services will be recorded in the young person's transition support plan.

If the young person does not meet the criteria for a specialist service in health or social care, then the lead health or social care professional in children's services will liaise with the young person's GP.

Further details of the Lead Professional role can be found in the role descriptor at Appendix 4 and embedded below.

https://sid.southampton.gov.uk/mediamanager/southampton/directory/files/lead-professional-role.pdf

3.6 Transition Support Plan

Every young person with additional needs transitioning from children's to adult's services should also have a Transition Support Plan. It is the responsibility of the lead professional/s in Children's Services to start pulling this together between the ages of 14 and 16, engaging the Adult Lead professional (or young person's GP if they do not meet eligibility for specialist Adult Services) from age 17 onwards to further develop the plan.

The Transition Support Plan should set out:

- The young person's aspirations for adulthood.
- An up to date assessment of the young person's needs and support required to meet them.
- A risk management plan.
- How the young person will be supported once they are an adult.
- The actions required, by when and by whom to ensure a smooth transition to adult services.

It is the responsibility of the lead professional/s in both children and adult services to oversee the Transition Support Plan, ensuring that actions are completed.

A template for the Transition Support Plan can be found here

https://sid.southampton.gov.uk/mediamanager/southampton/directory/files/transition-support-plan-template-2018.pdf

4. Transition protocols, eligibility and assessment for specific areas

The pathway and processes for transition described in the above section should be followed for all young people with additional needs transitioning to adult services. This section covers any specific requirements for specific areas.

4.1 Adult Continuing Health Care

NHS Continuing Healthcare is defined as NHS funded community based care and support for individuals over the age of 18 years who meet the criteria for funding as detailed in The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care, October 2018 (Revised).

The Framework sets out the principles and processes by which eligibility for funding under Continuing Healthcare is determined. Principles for transition to adulthood in relation to Continuing Healthcare are also set out in The National Framework.

It is recognised that not all children who are eligible for Children's Continuing Care will be eligible for Continuing Healthcare as adults. It is therefore essential that eligibility is determined before the child reaches 18 years old in order to prevent any disruption in care and support provision.

Children's services should begin to identify children that may be eligible for Continuing Healthcare from 14 years old.

During the young person's 16th year the National Continuing Healthcare eligibility screening tool or 'checklist' should be undertaken by the children's lead professional for the young person and submitted to the relevant CCG. The CCG will use this checklist to determine if this indicates that a full assessment of eligibility is required.

If a full assessment for Continuing Healthcare eligibility is indicated by the checklist this should be completed as soon after the young person's 17th birthday as possible and submitted to the relevant CCG. At this stage any eligibility and associated funding decisions will be 'in principle' and applicable from the young person's 18th birthday. The purpose of assessment early during the 17th year is to facilitate timely planning and commissioning of support services in adulthood to ensure smooth transition to adult services. If the young person's needs are likely to change, it may be prudent to repeat the eligibility process nearer adulthood.

It should be noted that the 28 calendar day timescale between checklist and eligibility decision laid out in The National Framework does not apply to young people in transition to adulthood.

The completion of the Decision Support Tool that constitutes the assessment of eligibility for Continuing Healthcare should be undertaken by someone who is familiar with The National Framework working in conjunction with professionals from children's services, that are familiar the child's needs, the child themselves and their family.

The National Framework details how to address issues of mental capacity and consent; responsible commissioner and disputes around eligibility decision making. This guidance should be followed by all parties.

4.2 Adult Mental Health (AMH)

Specialist Adult Mental Health Services in Southampton are provided by Southern Health Foundation Trust for adults 18+ with enduring mental illness. The eligibility criteria for specialist Adult Mental Health Services are detailed in the document link below:

www.southernhealth.nhs.uk/_resources/assets/inline/full/0/104609.pdf

If a young person is believed to meet the AMH criteria, communications between CAMHS and AMH should start no later than the young person reaching 17.5 years old and a formal referral should be made. Further information about referrals can be found in the above same link.

Adult MH Services will meet with the young person and their family at the earliest opportunity to discuss transition and clarify the young person needs so that the appropriate service can address these in a timely way prior to or during a transitional period agreed with the young person and family/ carer.

It is the expectation of AMH and CAMHs services to return the young person to the lowest step possible in relation to health and social care provision. The focus is always on supporting the strengths of the young person and their family to use local resources as close to primary care as possible.

This may result in:

- Transition to Primary Care Service GP for common mental health conditions.
- Use of Steps to Wellbeing for individuals (Improved Access to Psychological Therapies) with some low level psychological difficulties.
- Guidance and advice given to refer to an age related service such as No Limits as this is more appropriate for the young person to meet their need.
- Access to the Vulnerable Adults Team based within social care and access through the SPA.
- Adult Autism Team for assessments.
- Signposting to voluntary services such e.g. The Samaritans, No Limits Counselling and Re:minds Support Group.

4.3 Adult Learning Disability (LD) Health Team

Specialist Adult LD Health Services in Southampton are provided by Southern Health Foundation Trust. The criteria for specialist Adult LD Health Services are detailed in the link below:

www.southernhealth.nhs.uk/services/learning-disability-services/community-learning-disability-teams/

The young person and their family should be given information about the Learning Disability service in order that they have realistic expectations of what to expect. Any choices that can be made should be made by the young person themselves, with the help of their family, other professionals and the Lead Professional from children's services.

For young person meeting Adult LD Health Service criteria, the children's services Lead Professional should liaise with the appropriate adult Learning Disability service. A referral from children's services to adult Learning Disability services should be made in writing with consent of the young person. The care plan should document the young person's and family's wishes and the young person's capacity to make decisions about their own healthcare.

Following referral, a multi-agency review will take place in line with care planning between children's services and the young person and their family/carer. Following this review there will be a professional discussion between the children's services and the adult Learning Disability service to agree the transition and transfer process.

Once the referral has been accepted by Adult Learning Disability services the Adult Service Lead Professional (sometimes called care coordinator) will be identified. S/he will work jointly with the Lead Professional from children's services and will take over the responsibility for care co-ordination at the most appropriate point following the young person's 18th birthday, following a formal review/ transition meeting. There should be a discussion about who the young person would like to be present when s/he meets the new practitioner, and how the young person wants their family to be involved when the transition is made to the adult Learning Disability service. Vulnerable groups of young people include those who are working with a number of agencies because they are 'looked after', have committed offences, have a significant or multiple disabilities, or are the subject of a Child Protection Plan. For particularly vulnerable groups, the transition care planning should involve professionals from the relevant agencies and if necessary an advocate for the young person.

Response Times and Process

The adult Learning Disability service will be aware of potential transitions from children's services following information from TOG.

Where it has been identified that a transition and transfer needs to take place, there will be contact

between the children's Lead Professional and the adult Lead Professional (care co-ordinator) 6 months before the age of transfer of care.

An appointment will be offered to the young person within 7 weeks of the Adult Learning Disability team receiving/accepting the referral. This appointment will be a joint meeting with the young person and any other relevant people. The young person (and their carers) will be kept informed during this process.

Young people may be offered the opportunity to meet the practitioner from the adult service together with the Lead Professional from children's services on one or more occasions. This will provide the adult Learning Disability team Lead Professional (care co-ordinator) the opportunity to talk to the young person about what support they need, and who they want to be involved.

If the young person chooses, the adult Learning Disability team should copy the assessment letter to the parents as well as the young person (this should be documented).

The young person's preferred contact number should be noted and used as well as that of their carer(s) with consent.

There should be some discussion with the young person about how adult Learning Disability services respond if parents/carers do not attend and if the young person wants their parents to be informed/involved.

When parents do attend appointments with a young person's consent, they should be given adequate information about how they can support the young person.

Joint Assessment for young people with dual mental health and learning disability needs or young people who do not meet Adult LD criteria

A young person may present with a Mental Health or Learning Disability need which may require joint assessment/intervention from Community Mental Health and Community Learning Disability services. A protocol is in place within SHFT which clarifies the operational arrangements between the two services to ensure service users and their carers are supported from both or either service as appropriate.

In instances where a young person does not meet adult Learning Disability team criteria, children's services will need to liaise with other partner agencies including GP, Education, Social Care and any other appropriate community service who can offer on-going support to the young person and their family/carers to plan transition and transfer of care.

4.4 Adult Social Care & Financial Assessment

Strengths-based practice is a collaborative process between the person supported by services and those supporting them, allowing them to work together to determine an outcome that draws on the person's strengths and assets. As such, it concerns itself principally with the quality of the relationship that develops between those providing and those being supported, as well as the elements that the person seeking support brings to the process. Working in a collaborative way promotes the opportunity for individuals to be co-producers of services and support rather than solely consumers of those services. The phrases 'strength based approach' and 'asset based approaches' are often used interchangeably. The term 'strengths' refers to different elements that help or enable the person to deal with challenges and in meeting their needs and achieving their desired outcomes. These elements include:

- Personal resources, abilities, skills knowledge, potential etc.
- Social network and its resources abilities, skills etc.
- Community resources also known as 'social capital' or 'universal resources'.

For example: exploring with the young person and their family/carers what things they can do for themselves with the resources they have, such as using technology for online shopping, or for finding services required by the person such as cleaning or handy person services. Alternatively having undertaken an assessment, the person identifies that they have a good social network and has friends visiting frequently during the week who are also happy to provide support on these occasions and the person would prefer this. Using some of these solutions may mean that formal social care services are not required for some parts of the overall care and support package and the person is able to maintain their independence and social contact. Formal social care services deliver against outstanding needs and support the person to achieve their desired outcomes.

The council continues to have a duty to provide preventative services and contribute towards preventing, reducing or delaying the care and support needs of those people, adults or carers to whom the council provide care and support and the wider community (Care Act 2014 S2). For young people who are currently open to Children's services, their lead professional would present the young person initially at TOG. Through conversations at TOG and information provided by the Lead Professional, a recommendation will be given to the Lead Professional to state which Adult Team the young person should be transitioned to, and/or which other services or agencies could be involved. The Lead Professional is then expected to complete a referral to Social Care Connect and information about this can be found on the following link:

www.southampton.gov.uk/health-social-care/adults/adult-social-care/social-care-information.aspx

The referral will need to make clear that the young person has been discussed at TOG and that the agreed outcome is for referral to the LD health team. Social Care Connect will take the referral details and forward this via an electronic recording system, to the LD Team for allocation. Whilst a client is awaiting allocation within the LD Team, they are able to utilise the Duty Social Worker for any immediate needs or queries.

For young people who are not currently open to Children's services; the young person, their family or professionals can self refer to Social Care Connect who will triage the referral and forward on to the most appropriate team. In order for a young person to be referred to the LD team, we would require confirmation that they have a learning disability – this could be a cognitive assessment, or confirmation from the young person's GP.

When a worker in the Adults LD Team is allocated to work with a transition case, they will make contact with the lead children's services professional who is actively involved, and seek to arrange a joint visit with that worker, the client and their family to introduce themselves and to answer any questions or queries about the transition process and Adult Services.

The allocated Adults Social Worker will not initially focus on eligibility criteria and assessments. Instead they will have an initial conversation with the young person and their parent/carer to understand their concerns, see what they have tried already, and try to get them to the right place to help them. That 'right place' may be a conversation with one of the social care team at one of the Community Clinics, but it may be a peer support or a community group. The types of conversations had are described below:

Conversation 1 - Connecting people

This is about considering what is already going on in a young person's life, what is important to them and whether there are other individuals, groups and services in their community that can help with the current issue.

Conversation 2 - Responding at a time of crisis

Crisis conversations focus on the immediate, short term action such as enablement and may be required to get someone through a sudden change in their circumstances. No long term plans or decisions will be made at this stage.

Conversation 3 - Planning for the longer term

Following assessment, the Adults Social Worker will be able to confirm a fair personal budget for meeting identified needs and outcomes. The Care Act assessment focuses on ten domains of daily living needs, including managing and maintaining nutrition, maintaining personal hygiene, managing toilet needs, being able to make use of the home safely, maintaining a habitable home environment, developing and maintaining family or other relationships, making use of facilities and services in the local community include transport, accessing and engaging in work/training/education or volunteering and carrying out responsibilities the adult has for a child (if applicable). In order to meet eligibility for social care provision, a young person needs to be unable to meet at least two of these domains, and for this to result in an impact upon the young person's wellbeing.

When discussing the transition process, Adult Social Care will discuss the Client Contribution Charging Policy and request that the person who is responsible for managing the young person's finances (this may be the young person themselves) read and sign a 'Southampton City Council Consent to Care Act 2014 Financial Assessment and Agreement to Pay for Services' form. The criteria for financial assessment are different, depending on whether services are received at home, or in a residential or nursing setting. Once this form is signed and it is known what services the young person is likely to require (specifically whether this will be residential care or not), the social worker will send a request to the Financial Assessment Bureau (FAB) who complete the financial assessments. The FAB team will contact the billing representative (the person who is managing the young person's finances) or the young person themselves, in order to complete the financial assessment – this assessment will take into account the income that the young person receives and any capital (excluding the home that the young person lives in) or significant savings above £23,250 that the young person may have. If the young person has savings or capital (excluding their main home that they live in) above the threshold of £23,250, the young person and their family/carers will be supported to source and fund their own care services.

If a young person is receiving a package of care, they will be assessed to ascertain what, if any, client contribution charge they will be required to make. Client contribution charges are invoiced to the billing representative for the young person (or the Young People themselves if they manage their own finances) monthly.

4.5 SEND – Transition to further education, employment or training

For young people with SEND, it is essential that there is clear planning and focus on future goals and aspirations regarding employment, further education/training, independent living and community participation. This should be developed through the curriculum and extra-curricular provision.

Schools should encourage and help facilitate ways to help young people get exposure to examples of other disabled people who have been successful in their work and lives to help inspire and model what is possible. Partnership should be formed between schools, employment services, businesses, leisure organisations and other agencies to help young people understand what is available to them as an adult.

Personal Budgets can be used for young people with EHCP's to help them access activities which promote greater independence and learn important life skills. All services provided by the Local Authority should help prepare the young person for life as an Adult.

For children with an ECHP, schools have specific duties as per section 8.9 Of the Code of Practice in relation to preparation for adulthood which must begin form year 9 onwards at the latest.

4.6 Transition from Youth Offending Team

All young people who turn 18 whilst subject to a statutory Court Order will be considered for transfer to adult probation services (either NPS or CRC depending on level of risk) under the Hampshire area Y2A Transitions Protocol embedded below and in Appendix 3. The appropriateness of any transfer will be discussed at quarterly transitions meetings held between operational managers from Southampton Youth Offending Service (SYOS), National Probation Service (NPS) and Community Rehabilitation Company (CRC). Any decision to transfer to adult probation or keep supervision with SYOS will be based on a number of factors including type and length of order, level of young person's maturity and access to services in the local community.

Some orders will not be transferred to adult probation and in these circumstances transition to adult health services will need to be considered (e.g. Adult LD Team, Substance Misuse Services, Adult MH Team).

https://sid.southampton.gov.uk/mediamanager/southampton/directory/files/transition-support-plan-template-2018.pdf

4.7 Care Leavers

Pathways is the Children's Social Care Team that works with Looked After Children aged 14+ and Care Leavers, the aim being to support them through to adulthood as they develop the skills necessary for more independent living. Some of these young people have additional needs that are likely to require the involvement of ongoing support services beyond the young person's 18th birthday. It is a task for Pathways workers to identify these young people as soon as possible, preferably between their 16th and 17th birthdays so they can be referred at 17 to Adult services via the monthly Transition Operational Group (TOG). TOG has multi agency representation which spans Children's and Adults services and they collectively review referrals and make a decision about whether or not the young person meets the eligibility criteria to receive a service from Adult services once they have turned 18. Services to young people leaving care should be delivered in a co-ordinated way so where possible Children's and Adults services should work collaboratively to achieve this.

5 Involving young People, Their Family and Their Carers

The participation of children/young people and their parent/carers in decision making is one of the key principles of the SEND Code of Practice, and core to this Transition Guide. The Code stipulates that Local Authorities must ensure that the young person and their parents are involved in discussions and decisions about individual support regarding local provision.

The CQC 'From the Pond' document describes how children and their parents are often not prepared or informed well for the differences they are likely to face when their child is transferred into adult services. It reported examples of support plans that did not include the young person's wishes and a general lack of clarity, choice and options around locally available services for young people moving into adulthood.

It is therefore the expectation that the young person, their family and carers are central to transition planning and this should be specifically evidenced in the Transition Support Plan. Consent also needs to be addressed as the young person approaches adulthood, to ensure that they are asked about their care and the sharing of their information going forward.

As part of TOG's Quality Assurance role, the involvement of young people and their families in the transition process will be audited on an annual basis.

To support good transition planning, the Parent Carer Forum will also organise and host an annual Transition Fair in conjunction and with support from Southampton City Council (as part of its annual Local Offer event in Southampton) to provide parents/carers and young people with the opportunity to learn more about the help, support and services available. This will be supported by local health, education and social care services as well as wider support services and groups in the voluntary and community sector.

6. Safeguarding

Safeguarding is everyone's business and should be considered where appropriate to the transition planning process. There should be assurance that young people are safeguarded from harm at all times whilst they transition to adult services and in the support they receive in adulthood. This includes ensuring that they have a positive experience of care and are treated and cared for in a safe environment and protected from avoidable harm.

The Transition Support Plan will need to evidence how safeguarding, where this is an identified component of any risk management plans, has been addressed. Safeguarding and promoting the welfare of children is defined in Working Together to Safeguard Children (2018) as:

- Protecting children from maltreatment.
- Preventing impairment of children's health or development.
- Ensuring that children are growing up in circumstances consistent with the provision of safe and effective care; and
- Taking action to enable all children to have the best outcomes.

Safeguarding adults is defined under Section 14.7 of The Care Act 2014 (DH May 2014) as:

- Protecting an adult's right to live in safety, free from abuse and neglect.
- People and organisations working together to prevent or stop the risk of abuse.
- Promote the adult's well-being and listen to their views.

Safeguarding adults at risk involves making enquiries to establish whether an Adult is experiencing or at risk of abuse. Where this is the case, and the Care Act S42 Criteria is satisfied, safeguarding plans should be put in place. This involves considering the views and wishes of the adult and taking his/her preferred outcomes fully into account. The Care Act 2014 s42 defines the responsibility of the local authority to make enquiries where it has reasonable cause to suspect that an Adult in its area :

- Has needs for care and support (whether or not the authority is meeting any of those needs),
- is experiencing, or is at risk of, abuse or neglect, and
- as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

Local Safeguarding policies can be found at:

- Southampton, Hampshire, Portsmouth and Isle of Wight Local Safeguarding Children Board (4LSCB) Policies, Procedures and Practice Guidance

  www.4lscb.org.uk/
- Southampton, Hampshire, Portsmouth and Isle of Wight Local Safeguarding Children Board (4LSAB) Policies, Procedures and Practice

  Adult Safeguarding Board. http://southamptonlsab.org.uk

7. Mental Capacity

In adherence with the Mental Capacity Act (2005), a young person's mental capacity to make decisions should be considered for children over the age of 16 years.

The principles of the Mental Capacity Act can be found in the below link:

www.legislation.gov.uk/ukpga/2005/9/contents

An assessment of an individual's mental capacity to make a decision must be completed for each separate decision the person is required to make. This is also applicable to their transition to Adult Services and needs to be clearly documented in the Transition Support Plan.

Organisations are required to have their own policy around use of the Mental Capacity Act and how to support individuals to make decisions.

8. Deprivation of Liberty Safeguards (DoLS) and Liberty Protection Safeguards (LPS)

From the age of 18 years consideration needs to be given as to whether the care and support being provided within the community either in a residential home, supported living facility or in the person's own home is being delivered in a way that deprives the individual of their liberty.

Organisations will require their own processes for assessing and approving deprivation of liberty. Further information on DoLS in Southampton can be found in the below link.

www.southampton.gov.uk/health-social-care/adults/help-for-vulnerable-adults/dols.aspx

9. Advocacy

An advocate is an independent person who can support a young person to speak up about what they want to happen in their lives.

All young people with additional needs transitioning from children's to adult' services should be offered an independent advocate to support them during the transition process, with priority being given to those who might have difficulty engaging in the process and do not have a parent, carer or friend to support them.

Details of what independent advocacy support is available for young people in Southampton and how to access it should be available on the Local Offer Preparing for Adulthood pages. Parent/carers who need additional advice and information can also be sign posted to the Information, Advice and Support Service (IASS), details of which can also be found on the Local Offer.

Commissioners should ensure that there is sufficient capacity and expertise available locally to provide independent advocacy for all those young people in transition who are likely to need it.

10. Local Offer

Part 4 of the SEND Code of Practice lays out the duties placed on local authorities working in partnership with Health organisations and other partners to develop and publish a Local Offer detailing the services and support available for children and young people with SEND.

In Southampton, the Local Offer is published on the Southampton Information Directory and includes specific pages dedicated to Preparing for Adulthood. These include:

- Southampton's Transition Practice Guide
- Details of support and services available to support young people and families going through transition (including their rights in relation to Advocacy and Carers Assessments and how to access them).
- Details of support and services available in adult services to support young achieve the key Preparing for Adulthood outcomes:
  - Good Health • Employment (also including further/ higher education and training)
  - Independent Living • Friends, relationships and community inclusion

It is a requirement of all local organisations to ensure that the information about the support and care they offer is kept up to date on the Local Offer. The Southampton Local Offer can be found in the link below:

sid.southampton.gov.uk/kb5/southampton/directory/localoffer.page?localofferchannel=6-11

10. Local Governance for ensuring good transition

Ensuring that all young people are supported to reach their optimum potential and lead fulfilling adult lives and that specifically those with additional needs receive the support they need to prepare for adulthood through effective transition processes requires the commitment and collaboration of all agencies working together in Southampton.

Working together to improve the health and wellbeing of children and young people is therefore embedded in the city's partnership plans: Southampton City Strategy 2015-2025, Southampton City CCG's Operating Plan 2017-19, Southampton Better Care Strategy 2017-2019, the Health and Wellbeing Strategy 2017-2015 and the CCG's Local System Delivery Plan.

The City has identified 4 priority outcomes in the city strategy. These are:

- **Children and young people get a good start in life.**
- **People in Southampton live safe, healthy and independent lives.**
- **Southampton has strong and sustainable economic growth.**
- **Southampton is an attractive modern city, where people are proud to live and work.**

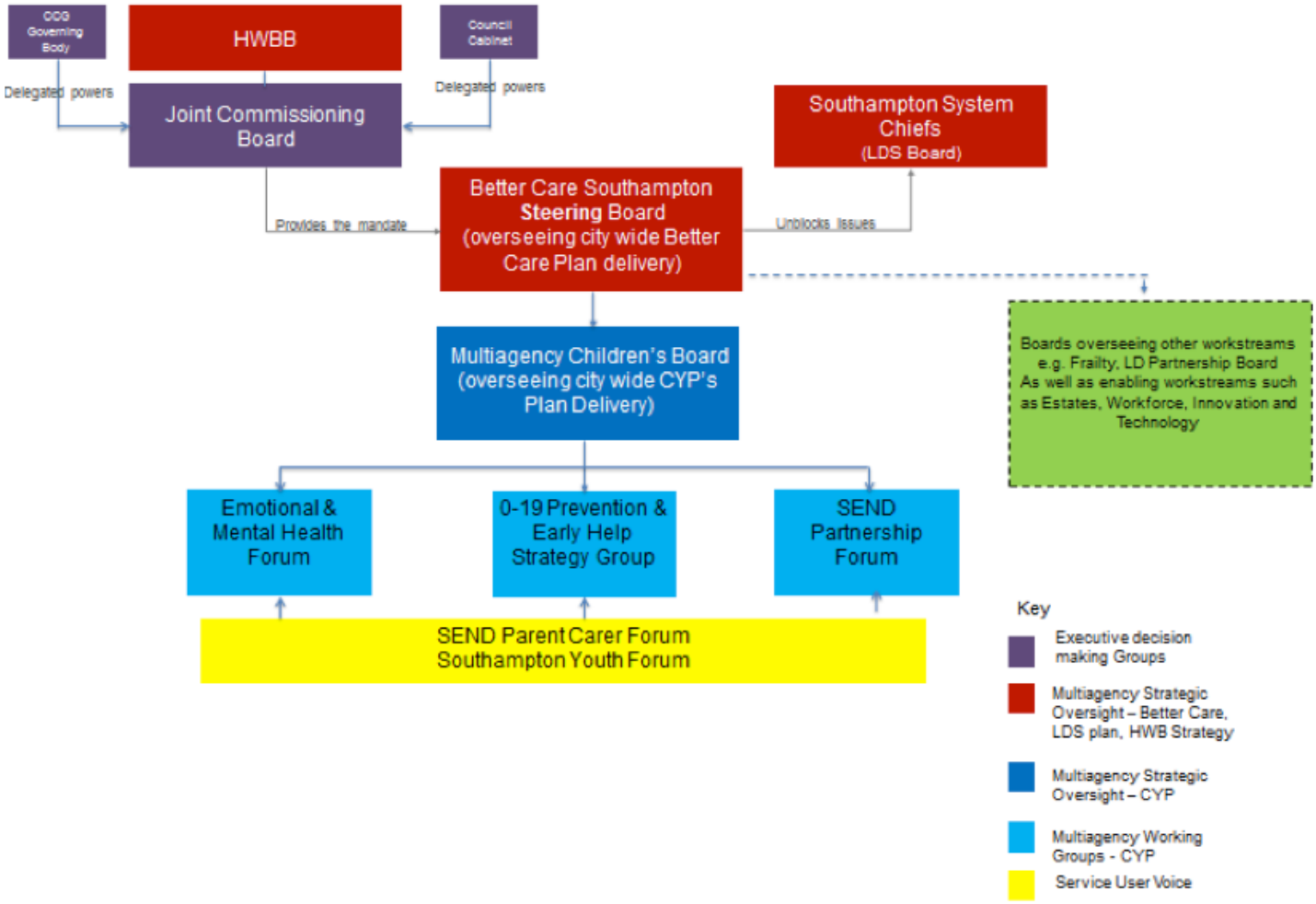
Supporting young people to lead fulfilling adult lives is included in the first two priority outcomes but is also key to achieving the second two outcomes.

Below the city strategy there is a city wide Children and Young People's Strategy which outlines the vision for children in Southampton to be happy and healthy, safe and secure, achieving and aspiring and ultimately resilient and prepared for the future:

The city's Children and Young People's Strategy is in turn underpinned by a number of other strategies specific to particular groups and themes, including the 0-19 Early Help Strategy, Education Strategy, Looked After Children and Care Leavers offer and the Southampton Special Educational Needs and Disabilities (SEND) Strategy 2017-2020

which includes 'developing greater autonomy, independence and resilience to prepare for adulthood' as one of its four key priorities.

In order to ensure delivery of the city's vision and key strategies through strong partnership working, including those specifically relating to improving outcomes for children and young people, including a good transition to adulthood, we have developed a strong multi-agency governance structure with a Joint Commissioning Board. How this relates to children and young people is shown in the schematic below:



Health and Wellbeing Board (HWBB)

Ultimately it is the **Health and Wellbeing Board** in Southampton that has strategic oversight of the health and wellbeing of people living in the city. This is a statutory partnership which meets every other month to consider the delivery of the Health and Wellbeing Strategy, Southampton's Better Care programme and other key strategies and plans for the city, which will include supporting young people to make the transition to adulthood.

Joint Commissioning Board (JCB)

The **Joint Commissioning Board** brings together senior leaders in the CCG and Council (including CEOs and lead members) with delegated powers to make decisions on behalf of the CCG Governing Body and Council/Cabinet to commission services jointly and pool funding where this will improve outcomes for local people. This Board will oversee any joint commissioning decisions in relation to supporting young people's transition to adulthood.

Better Care Steering Board

The **Southampton Better Care Strategy Board** brings together senior leaders from the CCG, Solent NHS Trust, University Hospital Southampton NHS Foundation Trust (UHSFT), Southern Health NHS Foundation Trust, Southampton Primary Care Ltd (local GP federation), Southampton City Council and Southampton Voluntary Services to drive forward the integration of health and social care, across adult and children's services, in each of the city's local neighbourhoods. The Better Care Strategy Board reports to the HWBB.

Multiagency Children's Board

The **Multiagency Children's Board** brings together the CCG, City Council Children's Services and Solent NHS Trust Children's Services to jointly plan and oversee key outcomes and strategy relating to children and young people in the city. It is one of several multiagency strategy groups which sit underneath the Better Care Steering Board. Below this are a number of multiagency partnership groups with broad representation, including strong links to the City's SEND Parent and Carer Forum and Youth Forum to ensure that the service user's voice is central to service planning. These include:

- SEND Partnership Forum which brings together leads from across the health (children and adult services - Solent and Southern Health), children's and adults social care, education, voluntary sector and parent/carer Forum and is the group that has been instrumental in pulling together this Transition document.
- 0-19 Prevention and Early Help Strategy Group.
- Emotional and Mental Health Forum.

References

The Care Act 2014 (s58-66)

www.legislation.gov.uk/ukpga/2014/23/part/1/crossheading/transition-for-children-to-adult-care-and-support-etc

The Children and Families Act 2014

www.legislation.gov.uk/ukpga/2014/6/contents/enacted

National Service Framework: children, young people and maternity services (DOH 2004)

www.gov.uk/government/publications/national-service-framework-children-young-people-and-maternity-services

Transition: getting it right young people (DOH 2006)

https://webarchive.nationalarchives.gov.uk/20130123205838/

Moving on Well: A good practice guide for health professionals and their partners on transition planning for young people with complex health needs on a disability

https://www.bacdis.org.uk/policy/documents/transition_moving-on-well.pdf

SEND Code of Practice

https://www.gov.uk/government/publications/send-code-of-practice-0-to-25

Aiming high for disabled children: delivering improved health services (NHS confederation 2009)

http://www.nhsconfed.org/~/media/Confederation/Files/Publications/Documents/aiming_high_sep09.pdf

The Children Act 1989: Guidance and Regulation volume 3: Planning Transition to Adulthood for Care Leavers (2010)

https://www.gov.uk/government/publications/children-act-1989-transition-to-adulthood-for-care-leavers

Social Care Institute for Excellence, Mental Health Transitions for Young People (SCIE, 2011)

https://www.scie.org.uk/publications/guides/guide44/introduction/

Transition from children's to adults' services for young people using health or social care service: NICE Guidelines

https://www.nice.org.uk/guidance/ng43

Preparation for Adulthood

https://www.preparingforadulthood.org.uk/

Care quality commission – From the Pond into the Sea

https://www.cqc.org.uk/sites/default/files/CQC_Transition%20Report.pdf

Independence: well being and choice (DOH 2005)

Bridging the Gap: health care for adolescent (RCPCH 2003)

Appendices

APPENDIX 1:

Transition pathway

https://sid.southampton.gov.uk/mediamanager/southampton/directory/files/transition-pathway-diagram-2018.pdf

APPENDIX 2:

TOG TOR

https://sid.southampton.gov.uk/mediamanager/southampton/directory/files/tog-terms-of-reference.pdf

APPENDIX 3:

APPENDIX 3: Provider protocol for Youth Offending Scheme (YOS)

https://sid.southampton.gov.uk/mediamanager/southampton/directory/files/pan-hampshire-y2a-policy-and-procedures.pdf

APPENDIX 4:

Lead Professional

https://sid.southampton.gov.uk/mediamanager/southampton/directory/files/lead-professional-role.pdf

APPENDIX 5:

Transition Support Plan

https://sid.southampton.gov.uk/mediamanager/southampton/directory/files/transition-support-plan-template-2018.pdf

SOUTHAMPTON
CITY COUNCIL

NHS
Southampton City
Clinical Commissioning Group