Children's Services
Overview and Scrutiny Committee

Agenda Item No.

31st January 2022

6

Transition to Adult Services

Ward(s): All

Portfolios: Councillor Wilson – Children's and Health and Wellbeing

1. Executive Summary:

Section 17 of the Children Act 1989 places a general duty on Local Authorities to provide services to safeguard and promote the welfare of children within their area who are in need, with specific requirements for supporting children who may have additional needs. In addition, statutory agencies have a duty to assess, and if necessary, support those that may require additional support beyond their minority.

When preparing for adulthood, supporting a young person with needs around education health or social care requires a pathway that is clear, succinct and in sufficient time for all supporting professionals to have agreed what support they will require. Transition is not a single event, but is a gradual process of supporting a young person and their family through their teenage years and into adulthood, building up their confidence and ability to manage with the care and support they need. The process should begin around the age of 14 years and should be planned in consultation with the young people themselves, their parents/carers and any professionals that may be involved. A good transition plan should work with the young people themselves, build on their strengths to plan for how they can meet their aspirations in adult life.

2. Reason for Scrutiny:

For assurances to be provided in relation to the transition process and to update members as to proposals moving forward. This report aims to outline the work that has, and continues to be undertaken in regards to transitions between children's and adults social care.

3. Recommendations:

For progress and achievements to be endorsed and proposals moving forward to be supported.

4. Background papers:

None to consider.

5. Resource and legal considerations:

The duties and legal considerations in regards to transitions are outlined within the following legislative frameworks:

- Care Act 2014
- Children Act 2004 (as amended)
- Education Act 1996 (as amended)
- SEN Code of Practice 2001
- Carers and Disabled Children's Act 2000
- Promoting the health and wellbeing of LAC 2015
- Children and Social Work Act 2017

There are no current resource implications that need to be outlined within this report.

6. Council Corporate Plan Priorities: Citizen Impact

The focus of our improvement in regards to transition planning falls under our corporate priority to ensure inequalities are reduced and all potential is maximised.

7. Environmental Impact:

Not applicable for this report.

5. Reducing Inequalities:

In line with our corporate priorities, Walsall sets out the response to secure improvements in the equality of services, which when achieved, will have a positive impact on our most vulnerable children and young people. Local Authorities, Police and Health Services as key local partners must provide a robust safeguarding approach to ensure they have arrangements in place to provide equal protection for all of our children.

7. Respond and Review

Our response and service provision to children in need is managed through our quality assurance processes and performance management arrangements. This area of work is also externally reviewed for quality and effectiveness by Ofsted through social care and SEND inspections. The work being undertaken in relation to transitions is also reviewed and monitored through our SEND Local Area Improvement Board, of which there are members from across the partnership which provides scrutiny and challenge in all areas relating to SEND. This board is also represented by parents and carers.

Issues for improvement identified through these routes are acted upon to ensure that we continue to provide the best possible services and support for children in Walsall.

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Introduction

Services for some young people who receive support from children's health and social care may end when they turn 18. For others, and particularly those with additional needs and/or those leaving care, will require support post 18 and potentially well into adulthood. Some of these young people will then go on to receive support from adult health and social care services and as such, the level of support that they may require needs to be planned in advance and agreed by all those involved. This period of change from being a child and preparing for adulthood is referred to as 'transition'.

During the period of 'transition' a young person will begin to get ready for leaving the support offered by children's services and becoming an adult. There are four key areas which a young person should be assisted to prepare for, these are:

- Education and/or future employment
- Independent living
- Friends, relationships and community links
- Health and wellbeing

Partner agencies all have a duty to ensure young people are supported as they 'transition' into adulthood. There are 3 main cohorts of young people that are identified as particularly likely to need support. These cohorts are:

- Young people who are in the care of the Local Authority
- Young people with Special Educational Needs and/or Disabilities (SEND)
- Young people entering adult services

Though three clear cohorts have been identified, it is recognised that there are overlaps between these groups, for example a young person might be looked after and have a disability. Moreover, the needs of each young person will be individual and as such clear and timely planning is required to ensure that the correct support is offered in good time for them to reach their full potential in adulthood.

Transition in Walsall

Currently in Walsall, for most children, their transition to adult passport is completed by the Child's allocated Social Worker once a child turns 16 and tends to be generated from an assessment or review of their plans whether this is Child in Need, Child Protection or Children in Care. This document is embedded into our Mosaic recording system and has been designed as a referral document from the child care social worker to the adult's social worker. The purpose of this document is to provide all relevant information in one easy accessible place to aid transition. It includes information around family and support networks, identifies key professionals such as school and health. It also outlines previous and current involvement of significant others and identifies risk factors and any other critical issues. This referral should trigger a period of joint working between the child's and adult's worker, where both the children's and adults workflow is being followed as part of a joint working arrangement.

We are currently working with our performance colleagues and partners in early help to ensure that they have a clearer process on how to trigger the process for those children that are open to

Early Help services rather than Childrens Social Care, as some of the statutory triggers may not be in place for those individuals. Clarity on how these two referral pathways are responded to is set out below.

As part of the current referral process, the referral to adult services goes to the Learning Disability Transition Team and at that point, the decision is made as to which team is best to take responsibility for the referral. In the event that a young person is deemed to require additional support owing to ASD/Mental health issues then this is likely to be allocated to the Mental Health Team within Adults Social Care. The current criteria and referral process is as follows:

Criteria for LD and Transition Team:

- ✓ Child/YP who has confirmed diagnosis of a learning disability
- ✓ YP with an Education Health and Care Plan (EHCP) who has a Physical Disability
- ✓ YP with Autism if they have an EHCP and NO diagnosis for Mental Health

Criteria for Mental Health Team:

- ✓ YP with Autism (Who's primary need is severe and enduring mental health)
- ✓ Child/YP who has Mental Health difficulties following a period of Transition from Children's Services and CAMHS

Referral into Adults – where child IS known to Child Services:

1. Passport to adulthood referral made by children's workers in MOSAIC. Accepted referrals can be received from age 14.
2. Work step is signed by Children's Manager
3. Work step comes into Learning Disability duty in box for screening, this applies to all cases regardless of diagnoses if already open to a children's worker.
4. Add them to LD awaiting allocation holding code for Transition (mosaic term)
5. Add to tracking and forecasting spreadsheets
6. Add note that case screened and is appropriate for LD and Transition Team
7. Cases are allocated according to their date of birth – however cases may be prioritised if there are additional complexities and allocated sooner

Referral into Adults – where child is NOT known to Child Services:
e.g. children known to education/schools/health but not to social care

1. Person will need to be referred directly through to Initial intake
2. Initial intake team open work steps for contact/contact referral work
3. Initial intake make enquiries to establish what team's criteria they meet
4. Then send referral directly to appropriate team for allocation

Owing to current resource pressures, whilst Adult Social Care are able to accept the referral at age 14, they are not always able to commence the assessment until a child is past their 17th birthday. For some children this may be too late. Likewise, in Children's Services, we need to be clear on what process we need to follow and do this in a timely manner in order to ensure that our young people are fully informed and prepared for life as an adult by ensuring the appropriate referrals are triggered early.

Preparing for adulthood, with a young person and their carers/family should be a seamless process. It should be one that ensures that the young person remains at the centre of everything and that the views of the young people themselves are both listened to, and incorporated into their planning. Walsall Partners are listening to our young people, their families and each other

in terms of how the preparation to adulthood process should work more collaboratively in order to improve experiences and achieve the desired outcomes, whilst also ensuring our statutory duty and responsibilities for young people are met.

In order to achieve this, a working group from across the partnership has been considering the effectiveness of our current processes and identifying ways of ensuring a more robust approach is adopted. This has included Managers and Practitioners from both Children's and Adult Services, Health and Education representatives, Commissioning leads, Youth Justice and Early Help Colleagues. As a result, a 3 stage Transition Toolkit has now been drafted and will act as a practice guide for professionals supporting young people into adulthood. In addition, a separate guidance for young people and their families is being designed as part of a co-production piece of work drawing upon the support from our young people themselves, their parents and carers.

The stages of transition are broken down into ages and are as follows:

- Stage 1 – Getting Ready for Transition (aged 14 – 16)
- Stage 2 – Starting the Transition Plan (aged 16 – 18)
- Stage 3 – The Transition Plan (aged 18 – 25)

In addition, the Local Authority and CCG are currently developing a Memorandum of Understanding designed to assist greater collaboration and integrated working to find joint solutions, integrate services and funding alignment through commissioning services. This Collaborative Commissioning approach, using data and intelligence, will enable whole system planning to design and develop services, reduce unnecessary duplication and enable efficient and cost effective provision. Having joint decision-making processes, partners can support early identification of needs, generate prevention and better manage outcome-focused service delivery.

Representatives from both Children and Adult Social Care will co-chair a Transition panel as a multi-agency forum to agree and take accountable action to support and plan as young people pass through the 3 stages. CCG health partners and education representatives will participate in all arrangements throughout the Transition Stages for those aged 14+ and contribute to seamless transfers and referrals into agencies who provide adult health, adult social care and adult education services.

Transition Toolkit – an overview

For young people to be supported properly during transition, it is important that everyone works together and is clear about their own and other people's roles. This transition toolkit is a practice guide and resource pack which can be used by anyone that is involved in supporting a young person transitioning into adulthood. The aim of this toolkit is to ensure that the transition between adults and children's services is in line with legislative frameworks and based on restorative and strengths based practice. Along with key partners in Health, Education and Voluntary Sector Services, our aim is to secure the best outcomes possible for young people by providing clear guidance and support for practitioners and to help parents, carers and young people, to understand:

- what help they can expect
- when they will receive it

- who is responsible for each element of the services and support they may expect or aim to receive.

In order to provide clarity on when preparatory work should commence, as stated, this toolkit has broken the stages of transition into 3 sections according to age and when levels of support are needed. All young people are treated individually and the levels of support will differ according to their needs. Disabled Children and Young People have a range of complexities that mean additional support post 18 will be extensive and as such the planning for their transition may need to start sooner. Equally, some young people may develop additional needs much later and may require additional support from adult mental health services as they approach the age of 18. As circumstances for young people will differ, the need to fully assess and understand their needs as soon as possible is a critical part of ensuring the right support is identified as part of the transition process.

As the needs and circumstances of each young person will vary, (i.e being a child in care) this will also determine what support is provided, when and by whom. If a young person is likely to require support once they turn 18, the Local Authority has a duty to assess those needs. This may lead to services to support them or signposting to services in the community so the young person can remain as independent as possible. If a young person does not meet Adult social care eligibility, then there may be support in the community to enable them to maximise their independence and so this will need to be identified as part of the transition process.

For young people with complex and life-threatening health conditions, their transition to adulthood will need to be underpinned by strong partnership working between children's and adult health services. This may involve community, hospital and hospice care teams. From the age of 14, health and social care professionals should begin to discuss with young people and their families the plans for transferring to adult healthcare, with the GP being a primary point of contact.

Healthcare professionals may also change as GP's, Continuing Health Care or District Nursing teams may play an increasingly significant role as the child gets older. Young People and their families/carers child should be introduced to any new professionals as part of the transition process as soon as possible so that they have the opportunity to discuss what changes to expect moving forward.

The Transforming Care Programme (TCP) aims to improve the lives of children, young people and adults with a learning disability and/or autism who display behaviours that challenge, including those with a mental health condition. Here in Walsall, our TCP cohort of young people are closely monitored to ensure their safety and wellbeing and are overseen as part of the Dynamic Support Register. The Dynamic Risk Register is a register of children and young people for whom there are concerns that they are at risk of Tier 4 hospital admission. A 'risk of admission' register can identify children and indicate what single or joint preventative intervention can be offered to reduce this risk or to proceed to a CETR (Care, Education and Treatment Reviews) to determine whether an admission can be safely avoided. The CCG leads on all CETRs and dynamic support Register as part of the Transforming Care Partnership (TCP) but the toolkit outlines the processes and key decisions that need to be made and at what point for all those children open to Children's Social Care that will require ongoing support as adults.

The toolkit has a number of documents to support assessments and clearly outlines the responsibilities of Walsall Local Authority and partner agencies in supporting children transitioning into adulthood. There are key issues that need to be considered such as:

- Resources and access to relevant services

- Link with other services such as Early Help as part of early preparation and support
- Consider who needs to be involved in the plan for the young person i.e Education/Health/CAMHS/Youth Services and other lead professionals.

This 3 stage toolkit aims to support improved decision making and will contain links to all relevant legislation and any other relevant practice guidance that may need to be considered as part of this process. As part of the development work being undertaken, all agencies involved in transition planning have been asked to provide information that can be incorporated into the toolkit. This includes specific links that can be accessed acting as a library of information for both social care staff and other professionals working with the family. The flowchart that will accompany the toolkit will also assist those supporting the process.

Actions moving forward

The toolkit is currently in draft form and input from most agencies has now been provided and incorporated. Final consultations as part of the working group needs to consider the additional links and resources that attach to the document and develop the flowchart that will accompany this. This is timetabled for completion by end of February 2022.

In regards to the guidance for young people and their families, we are currently canvassing support across our parenting/carers support networks, Transition and Leaving Care Service, Children in Care Council and Disabled Children's Parenting Support Groups in order to commence this work. Co-production is pivotal to ensuring that the right practical help and support is both understood and beneficial for the children and families it aims to serve. As part of the current working group, some research into how guides are used and received in other areas has been undertaken to assist us in what will benefit our young people here in Walsall. The aim is for this work to be completed and ready for distribution in April 2022.

A screening of current tracking processes and panels that assist with identifying young people is also being undertaken by the transitions working group. This aims to identify those that need to be involved in the new Transitions Panel and avoid any cross over from other governing processes. A terms of reference for the new Transitions Panel will be completed and finalised with partners in Adults and Children's Social Care, Health, Education and Commissioning. We are aiming for this work to be completed by end of March 2022.

The Memorandum of Understanding being completed collaboratively between health (CCG) and Social Care Commissioning Services is currently going through governance approval. This process will be completed by end of January 2022.

Decide

It is requested that the members of this Childrens Overview and Scrutiny Committee agree and endorse the actions as set out in this report.

Zoe Morgan – Head of Service, Help protection and Support