Preparing for Adulthood Transitions

ASC - Operational Policy

Preparing for Adulthood Transitions

Directorate:	Social Care, Health, and Housing (SCHH)		
Division & Service:	Adult Social Care – Community Assessment Service		
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It is the responsibility of every individual to ensure that they are working to the most current version of this document.

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1. Introduction

1.1 The Care Act 2014 places a duty on local authorities to conduct transition assessments for children, where there is a likely need for care and support after the child in question turns 18. and a transition assessment would be of 'significant benefit'.

1.2 Central Bedfordshire Council's (CBC) Young Adult and Independent Living Team (YAaIL) based in Adult Social Care (ASC), works with a variety of services including Children's Services (CS's), schools, health and mental health services to identify young people as early as possible. This enables the opportunity to plan for or prevent the development of care and support needs with the young person and fulfil the Council's duty.

1.3 The transition into ASC needs to be at an appropriate time for the young person, with the young person and their family fully informed of any changes and with no gaps in provision to meet the young person's assessed needs. A referral should be made to Adult Social Care by the young person's 17th birthday; however, discussions can take place from the young person's 14th birthday.

2. Purpose

2.1 This policy sets out the YAaIL Team's approach to transitions into adult social care. This covers identification of young people that are likely to have care and support needs when they become 18, referral, assessment, transfer and post-transition support.

2.2 The principles that guide an effective transition to ASC services are as follows:

- Timely referral.
- Early information sharing and monitoring to understand future commissioning needs.
- Active joint working between partners; this is to include co-operation, good communication and positive relationships between ASC, Health and Children's Services.
- Awareness and ownership of roles and responsibilities.
- Clearly agreed and communicated point of transition.
- Co-production, working with parents/carers and young people to be a responsive service.
- Early intervention and high aspirations for all children and young people.
- Preparing for adulthood- including independence support, training and employment.

Scope

2.3 This policy applies to all young people with a Special Educational Need and/or Disability who are likely to be eligible for support from ASC when they reach 18 years old.

2.4 This policy covers YAaIL's role in preparing a young person for adulthood, alongside the referral, assessment, decision and confirmed process of transfer.

2.5 This policy also covers transition for the young person's carer.

3. Legislation and Regulatory Framework

- **Care Act 2014**
  Outlines the duty to carry out a transition assessment for young person or carers, in order to help them plan, if they are likely to have needs when they (or the child they care for) turn 18.

- **The Care Act 2014 Statutory Guidance**
  Section 16 Transition to Adult Care and Support.

- **Children and Families Act 2014, Part 3**
  Introduction of Education, Health and Care Plans and requirement of local authorities to develop a Local Offer to inform children and young people with special educational needs or disabilities of the support available to prepare for adulthood. This legislation seeks to ensure that local authorities place children, young people and families at the centre of decision making, enable them to participate in a fully informed way, and with a focus on achieving the best possible outcomes.

- **Children Act 1989**
  Under Section 17(1) of the Children Act 1989, local authorities have a general duty to safeguard and promote the welfare of children within their area who are In Need; and so far as is consistent with that duty, to promote the upbringing of such children by their families, by providing a range and level of services appropriate to those children's needs.

- **Special Educational Needs and Disability Code of Practice (Department of Education/Department of Health 2015)**
  This Code of Practice provides statutory guidance on duties, policies and procedures relating to Part 3 of the Children and Families Act 2014 and associated regulations.

- **National Institute for Health and Care Excellence (NICE) Guideline on Transition from children to adults' services for young people using health or social care services**
  This guideline covers the period before, during and after a young person moves from children to adults' services. It aims to help young people and their carers have a better experience of transition by improving the way it's planned and carried out. It covers both health and social care.

- **The Equalities Act (2010)**
  This defines the public sector equality duty and disability as a protected characteristic.

Principles of the Policy

4. Identification

4.1 Young People that may have care and support needs at 18 can be identified in a variety of ways and referred by any agency or individual. These agencies or professionals typically include parents, school nurses, Children and Adolescent Mental Health Services link workers, GPs, early help settings, schools and Children's Services.

4.2 Early identification is important for planning and preparing the young person for adulthood and the YAaIL Team has a variety of routine monitoring methods to identify children known to partner agencies to check which referral is required. These are:

A. The YAaIL Team will receive information on young people that have Special Educational Needs or Disabilities and may need care and support at 18 from the following agencies:

   i. Children with Disabilities Team (CWDT).
   ii. Child and Adolescent Mental Health Services (CAMHS).
   iii. Corporate Parenting Team (this will be to identify young people who may need additional support during transition).
   iv. Special Educational Needs and Disabilities Team (SEND) and schools/ colleges.
   v. Early Help and Family Support Teams.
   vi. BLMK Integrated Care Board.

B. YAaIL officers liaise with a range of agencies working with young people and their families through the multi-agency partnership which provides a regular opportunity to identify young people who may require ongoing support.

C. The YAaIL team will request that the agency currently with care management responsibility makes a referral to the YAaIL Team, subject to the young person's consent.

D. If a young person is not known to Children's Services, a parent can refer to the YAaIL Team as detailed below, subject to the young person's consent.

5. Referral

5.1 A referral should be made to the YAaIL team when a young person (that is likely to have care and support needs at 18), reaches the age of 14.

5.2 A referral can be made by the young person or another person or agency with the young person's consent. Where the young person is under the age of 16, the referral can be made with consent where they are assessed as Gillick competent or with parental consent.

5.3 The referral can be made via the Self-service care and support enquiry e-form on the Council's website, or a telephone referral made 0300 300 8100/ 8000

5.4 Once a referral has been received, the young person's details will be entered on to the Adult Social Care system and an acknowledgement of receipt of the referral will be made within 5 working days.

5.5 Once the referral has been received, the service will review this to decide the initial level of priority given to the referral and add the young person to the Allocations Tracker. The level of priority is based on the young person's age and complexity of the young person's care and support needs and services currently being received.

5.6 The YAaIL Manager will allocate the referral to a YAaIL Officer who will make contact with the family and young person to introduce themselves.

5.7 It is key for the young person and family to have a single point of contact during the transition period. This will be the current allocated worker, from Children's Services who will liaise with the YAaIL Officer and other agencies to ensure effective coordination.

5.8 A referral will not be accepted if:

- there is no appearance that there may be needs after the 18th birthday.
- the consent condition is not met (s.58 Care Act 2014) and the young person is not experiencing or at risk of abuse or neglect.

5.9 If a referral is not accepted, the young person, their family and referring agency (if applicable) will be advised of the reasons for the decision by the YAaIL Officer and information and advice will be provided on universal services available to support the young person in the future.

5.10 If the young person or family dispute this decision, this can be discussed with the YAaIL Team Manager in the first instance. If the issue cannot be resolved through discussion, then the young person or family member is able to utilise Central Bedfordshire Council's Appeals protocol.

Late referrals

5.11 If the referral is made after the young person reaches the age of 17 ½, the YAaIL team cannot guarantee that support can be transferred when the young person reaches 18. If transition is delayed due to a late referral, the current care management service (e.g. Children's Services or CAMHS) must continue to meet the costs of care and support until acceptance of transfer is received from YAaIL. Exceptions will be made where the service was unaware of the young person before 17 ½ or their level of care and support needs did not trigger a referral before 17 ½.

6. Information gathering and monitoring.

Information gathering.

6.1 Through involving the young person, their family and agencies, the YAaIL Officer will gather information to understand the anticipated care and support needs of the young person at 18 and the anticipated cost of services post 18. This will include:

- Baseline of assessed needs.
- Eligibility for services.
- Current placement/ education setting details.
- Resources currently in place.
- Mental health status.
- Mental Capacity assessment where required.
- Continuing Health Care status.
- Current benefits received and use of mobility vehicles.
- Anticipated future need.
- Young person's aspirations post education and desired outcomes.
- Carers assessment or review.
- Clinical formulation plans, including Care Programme Approach (CPA).

6.2 This information is collected on Care and Support assessment and is stored on the Adult Social Care database.

Information gathering for commissioning purposes.

6.3 Information gathered from referrals on future service needs is also collated for commissioning purposes. The information is shared with CWDT, Health, Transforming Care Programme, ASC, Sustainability and Transformation Partnerships to understand gaps in current provision and whether new or additional services need to be commissioned.

Prioritising resources - 14-16 YAaIL involvement.

6.4 If the young person is likely to have care and support needs at 18, but an assessment at the time of the referral is not of significant benefit, the young person, their family and referring agency will be advised when the YAaIL team will begin to work with the young person.

6.5 The YAaIL team's involvement with the young person before 16 will be dependent on the level of risk identified, to manage YAaIL team's resources efficiently and effectively. Please see appendix 1.

6.6 Young people aged 14 and 15 identified as high-risk due to their anticipated care and support needs and the current services in place, should expect the following from the YAaIL team:

- Named YAaIL officer.
- Information of the YAaIL service including the Local Offer.
- YAaIL attendance at annual EHCP meeting.
- Appropriate information and advice.

6.7 Young people identified as low risk should expect:

- Contact details for YAaIL Team.
- Information of the YAaIL Team including the Local Offer.
- Contact to advise when work is likely to begin, this should be no later than 6 months. before their 18th birthday.

6.8 As a young person approaches their 18th birthday, the YAaIL Team Manager will change their risk status to reflect the timescale left to complete their Care Act Assessment.

Annual EHCP reviews

6.9 The YAaIL officer will, where possible attend annual EHCP reviews of the young people allocated to them, prioritising high risk situations where there are not sufficient resources to attend all reviews.

7. Assessment and planning

7.1 A referral must be received by a young person's 17th birthday to ensure that the young person can transition to adult social care services by the time they reach 18.

7.2 Young people aged 16 and 17 that have been referred and are likely to have care and support needs at 18, should expect:

- A Care Act assessment before their 18th birthday (subject to timely referral). Subject to capacity across the service, the aim is for a Care Act Assessment to be completed 6-months before their 18th birthday.
- The YAaIL team to work with the young person to start to complete their support plan (including contributing to their EHCP where there is one) in preparation for their 18th birthday (subject to a timely referral).
- Where appropriate secure funding and identifying appropriate adult social care services.
- Information and advice:
    - Information on Personal Budgets and Direct Payments, where appropriate, so they and their families understand whether they are eligible and what funding will be provided.
    - Signpost to services that can help young people identify and access their benefit entitlement.
    - Provide young people with independent information, advice and guidance to enable them to continue planning for the future.
    - Ensure young people and their families understand the funding arrangements if they want to continue in learning. Understanding the statutory responsibilities of SEND in providing services in line with an EHCP.

Care Act Assessment

7.3 A Care Act assessment will be carried out by the YAaIL officer ensuring the views and wishes of the young person are included. If the young person is unable to articulate their views, information will be gathered by speaking to those involved in their care and support; this will involve, parents, family members, carers, teachers etc. The young person, their family and current care manager will be advised of:

- the outcome of the assessment
- information on Personal Budgets
- application for a financial assessment
- explanation of the next steps.

7.4 If following a Care Act assessment, the young person is assessed as eligible for ASC care and support, the following action must be taken before care management responsibilities can be moved to Adult Social Care:

- Agreed support plan in place which has been developed with the young person and their family and takes in to account young person's wellbeing, individual needs, wishes, and outcomes which matter to that person, and meets their needs.
- Anticipated future needs including aspirations post education are documented.
- Mental Capacity assessments completed (to ascertain whether the young person understands their care needs and can make decisions around this as required).

- Deprivation of Liberty applications completed or being processed (to assess whether the young person is under continuous supervision and control and is not free to leave if applicable).
- Safeguards completed.
- Continuing Health Care application made (to ascertain whether the young person has a primary health need and is eligible for health funding if applicable).
- Financial Assessment completed (if applicable).
- Relevant onward referrals made to health and ASC.
- Carers assessment or carers services in place.

7.5 Ahead of the young person's 18th birthday (if the initial referral was timely), the YAaIL team will secure funding and provision of services set out in the support plan.

7.6 A Carer's Assessment will be discussed during completion of the Care Act Assessment for the young person. This can be completed before the young person turns 18, however, the YAaIL Team cannot provide carer's services until the young person turns 18.

Support planning

7.7 The YAaIL officer will work with the young person and their family to decide on how the identified care and support needs can be met. A support plan will be produced and agreed by the YAaIL officer, young person and their family.

Brokerage

7.8 The YAaIL officer will secure services in line with the young person's support plan and personal budget.

Transfer to YAaIL

7.9 The young person and their family will be consulted regarding the service providers, when the young person can start to access the services and how the services will be funded.

Continuity of services

7.10 Services provided by Children's Services under section 17 of the Children Act 1989 must continue until the YAaIL officer has completed the assessment and support plan and provided Children's Services written confirmation of transfer.

"If the local authority carry out the assessment before the child reaches the age of 18 and decide to treat it as a need or carer's assessment […], the local authority must continue to comply with section 17 after the child reaches the age of 18 until they reach a conclusion in his case. s.66(2) of the Care Act 2014."

7.11 To avoid confusion, the YAaIL team will notify the young person, their family, and the referring team when transfer will take place. Written confirmation will advise the date that the YAaIL team will be assuming care management responsibility and the date that the services will commence.

7.12 This confirmation will provide clarity around which team is responsible for the person's care management and the cost of that care. Existing services for the young person must not cease until the team has received this, to avoid any gaps in care and support.

Post-transfer

7.13 Once the 18-year-old has transitioned to YAaIL an officer will continue to work with the young person until such time that they are settled into any new services. YAaIL will undertake to review on an annual basis or when appropriate, if needs and circumstances change. Contact can be made with our First Response (0300 300 8100) who will offer support at the time or look to allocate an appropriate officer to support. It is likely that a young person will receive a period of continued support from a named worker until they leave school, and a future education or social care placement has been identified.

Young carers

7.14 The Care Act 2014 places a duty on local authorities to assess young carers before they turn 18, so that they have the information they need to plan for their future. This is referred to as a transition assessment.

7.15 Local authorities must conduct this transition assessment for a young carer where it appears that the carer is likely to have needs for support after they turn 18 and where they think that there would be 'significant benefit' to the carer in carrying out the assessment.

7.16 On the basis of a transition assessment, local authorities must give an indication of whether the young carer is likely to have eligible needs for support under the adult statute. They must also give advice and information about what can be done to meet those eligible needs, and what can be done to prevent or delay the development of needs.

Adult carer of a young person

7.17 Following referral, where it appears to the YAaIL team that a carer of a child is likely to have needs for support after the Young Person becomes 18, the YAaIL team will carry out a carer's assessment where it appears that the carer may have needs for support, either now or in the future.

7.18 A carer, in relation to a Young Person means an adult (including one who is a parent of the child) who provides or intends to provide care for the child. This does not include an adult that provides care under or by virtue of a contract, or as voluntary work, unless the YAaIL team allows this. (Care Act 2014, s.60 (8-9).

7.19 If the YAaIL team do not consider a carer to have appearance of need, now or in the future, the worker will advise the carer that a Carer's Assessment is not appropriate. They will provide information and advice about what can be done to prevent or delay the development of needs. This may include signposting to carer's services such as Carer's in Bedfordshire.

7.20 If the Young Person's carer refuses an assessment, no further action will be taken, however this does not prevent the carer from requesting an assessment later or a referral being made for an assessment.

8. Responsibilities

Referring agency (e.g. Children's Services, health and education)

8.1 Co-operate with agencies involved in arranging and providing the care and support for the referred young person. This includes participation in multi-disciplinary discussions in order to ensure joined up approaches to meeting care needs.

8.2 Prepare the young person for adulthood so that when the young person approaches 18, they have been given the opportunity to reach a level of independence that enables them to access the widest possible range of services to meet their needs.

8.3 Ensure that no legally binding financial commitments or contractual agreements are made that will impact on Adult Social Care budgets when the person reaches 18 without prior formal agreement from the Adults Service Operations Manager.

8.4 The referring agency is responsible for making a timely referral to enable the YAaIL team to engage with the young person to plan for transition by the young person's 18th birthday. Specifically, the referring agency should identify and refer young people that are likely to have a care and support need at 18 from when the young person reaches 14 to allow time to prepare and plan. A referral should be made no later than when the young person reaches 17 ½.

8.5 Prior to transition:

- Complete mental capacity assessments (where requested),
- Complete or initiate Deprivation of Liberty applications (if applicable),
- Complete safeguards, and
- Clinical formulation plans in place includes Care Programme Approach (CPA).

8.6 Continue care management responsibilities and funding until the YAaIL team notify the referring agency of the transfer date.

YAaIL Team

8.7 Co-operate with agencies involved in arranging and providing the care and support for the referred young person. This includes participation in multi-disciplinary discussions in order to ensure joined up approaches to meeting care needs.

8.8 Manage and prioritise referrals so that the YAaIL team's timing and level of involvement is proportionate to the young person's likely care and support needs post-18, taking in to account the YAaIL resources available.

8.9 Liaise with Children's Services/ Continuing Health Care to prevent any legally binding financial commitments or contractual agreements being made by Children's Services that will impact on Adult Social Care budgets when the person reaches 18 without prior formal agreement from the Adults Service Operations manager.

8.10 Liaise with the referring agency, young person and their family to ensure that that a timely Care Assessment and Support Plan is completed, enabling the transition to Adult Social Care services to be as seamless as possible for all concerned.

8.11 Prior to transition:

- Complete a Continuing Health Care assessment (the YAaIL officer will support the young Person's existing care manager),
- Arrange for a financial assessment to be completed (if applicable),
- Make relevant onward referrals to health and ASC,
- Complete carers assessment and if applicable arrange for carers services to be in place.
- Send written confirmation to referring agency, young person and their family of the date that care management responsibilities will transfer to the YAaIL team.

9. Equality and Diversity

9.1 The Council has a duty under the Equality Act 2010 to have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

9.2 All SCHH policies are accompanied by an EIA (where applicable) and an implementation plan that sets out monitoring and reporting arrangements available in relation to this policy.

9.3 The Council is proactive about putting in place arrangements to ensure that they do not unfairly discriminate against individuals on the grounds of their protected characteristics. Equality should be integral to the way in which any support is prioritised and delivered

10. Information and Training Responsibilities

10.1 The Operations Manager for the Adults Service will take lead responsibility. Responsibilities include ensuring staff awareness, effective implementation, ongoing monitoring, and practice development.

10.2 Relevant staff should be advised of the policy and advice/ information regarding the policy can be sought from the YAaIL team.

11. Evaluation and Review

11.1 This policy shall be reviewed every three years and will be evaluated within 12 months of approval and validation.

12. Appendices

- Appendix 1: Risk Matrix

Appendix 1: Risk Matrix

Priority 1	- High risk of carer breakdown. - Deterioration in health requiring a MDT approach. - Loss of carer. - Complex and challenging family dynamics presenting risks. - Mental capacity issues relating to an urgent decision around care and support. - DST attendance. - Not for S42 referral that requires urgent review due to police involvement or the serious nature of the allegation. - Situations that could quickly escalate to crisis and Duty has been managing. - Complex cases with MDT involvement. - Services serving notice. - Person moving from a care home or rehabilitation placement.
Priority 2	- Care Act Assessment requested for person aged 18+. - Family under strain and risk of carer breakdown. - Respite requests. - Review required due to the person or family raising concerns about existing services. - Request from a service to review changing needs. - Lower level not for S42 request for review. - DoLS request for review- relating to risk of S21A appeal.
Priority 3	- Care package review following hospital discharge. - Lower-level requests for review from services. - Assessments requests for day service attendance. - Funding threshold drop.
Priority 4	- Routine Carer's assessment. - 8-week placement review. - Request for annual review. - Future funding threshold drop.