PREPARATION FOR ADULTHOOD

TRANSITIONS PROTOCOL

WORKING TOGETHER TO PREPARE PEOPLE WITH ADDITIONAL NEEDS FOR ADULT LIFE

BIRMINGHAM CHILDREN'S TRUST

Birmingham City Council

NHS
Birmingham and Solihull
Clinical Commissioning Group

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1. WELCOME

Birmingham is committed to supporting young people with additional needs to prepare for adulthood. Transition is the period of time a person moves from childhood into adulthood and therefore moves from the support of children's services into adult services, this usually starts at the age of 13, or in school year nine.

The aim of this protocol is to support the vision of transition for young people with additional needs by setting out the guiding principles of good transition planning. By identifying the key elements necessary for good preparation for adulthood, including the integral responsibilities across partner organisations, timely and effective professional interventions can be made.

This in turn will ensure that at a time of great change and apprehension when young people with additional needs often have to confront changes to the health and social care services they have received as children, co-ordinated support is on hand.

Our goal is to secure the best possible outcomes for young people and their parents and families by putting the young people at the centre of the decision-making process. The protocol will be continuously monitored and updated to take account of any future changes, particularly in respect of legislation, best practice and/or departmental or cross departmental policy developments in respect of transition planning and preparation for adulthood.

This protocol reflects our collective commitment to ensure that young people with additional needs experience the same opportunities as other young people and go onto lead full and purposeful lives. We will do this by ensuring that our resources, commissioning and quality assurance activities collaborate to provide person centred services and opportunities that promote greater independence and life skills for the young people of Birmingham.

2. AIMS AND OBJECTIVES

The aim of this protocol is to clarify the role of each partner to simplify and promote better understanding of the process and approach involved in accessing support leading up to and during transition from children to adult services.

There is now a wealth of legislation and guidance that govern transition and the responsibilities of organisations. This protocol has been informed by such legislation and guidance.

Our collective aim is to secure the best possible outcomes for young people, their parents and carers and families by providing a clear pathway to support practitioners and to help parents, carers and young people to understand:

- What support they can expect
- When they will receive it
- Who is responsible for each element of the services they receive
- What is their responsibility

3. PURPOSE AND SCOPE

This protocol is intended for everyone involved in transition planning including staff who support the young person to prepare for adulthood. It will ensure that professionals, young people and their families/carers are all clear about the specific roles and responsibilities of each service area at each stage of the journey so that they can work together to support the young person who must always be at the centre of the preparation work for adulthood.
The protocol is intended to be the driving force for improving young people's experience of transition and preparing for adulthood in Birmingham, it will:

- State our collective commitment to ensuring that young people with additional needs receive appropriate support to prepare for adulthood at their own pace and maturity
- Ensure effective partnership working between services and young people, their parents and carers so that transition is not seen as the core responsibility of one Service or one individual
- Clarify which young people we should offer additional support to through the planning of the preparation for adulthood
- Set out outcomes, performance measures and standards to be achieved
- Set up effective person-centred planning and review
- Set out the roles and responsibilities of all the services working with young people
- Inform our joint commissioning cycle to enable us to respond flexibly to the needs of the local population of Birmingham

4. OUR BIRMINGHAM SHARED PARTNERSHIP VISION

Our shared vision for transition and the preparation for adulthood in Birmingham is: -

'Our joint vision is to use a life course, strengths-based approach to put children, young people and families at the centre of planning to access the right information and support for a rich and fulfilling life, with equal life chances as they transition into adulthood'.

5. OUR BIRMNGHAM PRINCIPLES

Our Birmingham principles are based on the expectation that planning for adulthood should be a continuous interactive relationship between professionals and the young person, which is person centred and driven by strengths of the individual rather than deficits and need.

The guiding principles that shape the Birmingham vision are:

- A no-compromise approach to ambitious outcomes
- An excellent range of options, and control over choice
- Excellent connections to communities
- Support when it is needed, and suited to each person's experiences
- Allowance for those who are life-limited to live their life now: education, friends, hopes and dreams
- Sharing amongst partners of information, knowledge and experience
- Funding shared, not hidden
- Use of language that is accessible and jargon-free, in all communications
- Challenge of mistakes welcomed, to inform collective learning and continuous improvement

Birmingham outlines four key areas of planning in its vision and guiding principles document that must function concurrently in order to realise a positive experience for young people and their families when preparing for adulthood. These are: -

- Effective planning and strong partnership engagement
- Working with high quality information
- Full participation of children, young people and their families
- An array of opportunities for living life

BIRMINGHAM

6. WHO IS COVERED BY THIS PROTOCOL?

The young people covered by this protocol are: -

- Young people in receipt of or who may be eligible for Children's Services

- Young adults in receipt of or who may be eligible for Adult Services
- Young people with an Education, Health and Social Care Plan or SEN support
- Children in receipt of or who may be eligible for continuing care or who have complex health needs
- Young adults in receipt of or who may be eligible for adult continuing healthcare
- Care leavers and LAC preparing for adulthood
- Young carers preparing for adulthood

7. THE TRANSITION PATHWAY

A successful transition has five key stages:

- Assessment
- Planning
- Review
- Funding
- Outcomes

The quality of transition depends on the quality of each of these stages and the detail of each will vary from person to person depending on their individual needs.

ASSESSMENT

Many young people to whom this protocol applies will have had one or more needs assessments prior to the transition process beginning, particularly people with significant disabilities and these should be considered as part of the wider assessment for transition. However, many of these assessments only focus on what a person can't do to inform decisions about what services and treatments they need to make up the deficit. Because of this they only tell a small part of the person's story and although they inform the transition plan, they cannot inform it in its entirety.

Good transition planning should encompass much more than education, health and social care services although these are fundamental to the process. A good transition plan should look at how the person wants to live their life as an adult and to inform this, a more comprehensive, in depth assessment is needed, one which has the person at the heart of it.

A person-centred assessment starts by looking at what a person can do: their skills, strengths and the personal qualities which others like and admire about them. It then looks at what is important to the person, the things that matter to them, the things

that they enjoy doing and their hopes for the future. Only then does it look at what is important for a person, usually the things that keep them safe and healthy. Most of the assessments a person has had in the past will inform this last category and all current assessment should be fed into this. These may include educational assessments, health assessments, skills assessments and social care needs assessments.

Central to this assessment process is the person him or herself. This means looking at what is important to the person first and then looking at what matters to others such as their family or professionals next. It will also look at what support is available to them from friends, family and community.

PLANNING

A good assessment will directly inform the outcomes of a good plan, but too often, plans focus almost exclusively on what services will be provided. A holistic, person centred plan starts by looking at how a person wants to spend their time and what they want to do in the short and long term. It then considers the skills and strengths they already have and the support they can call on from family, friends and community networks. Only then will it look at which services are necessary to fill the gaps.

Planning should begin at age 14 and should involve all relevant people and agencies. It should address three key questions:

I. What is important to the young person now and in the future and what support is wanted or needed

II. What is the best that could happen

III. What is practical and possible

REVIEW

Year 9 - The first transition review should take place during year 9 when the young person is 14. As with all transition reviews it should be called and chaired by the headteacher and include all relevant stakeholders, including all the people who are important to the young person. The review should be child centred and as well as considering what educational opportunities the young person wishes to pursue post 16, it should also consider wider issues such as what the person's long term goals are and how they should start to prepare for them by asking again the three key questions outlined above.

An initial transition plan should be prepared using person centred planning tools, on the understanding that many people do change their minds about their life plans at this age, and a person with additional needs is no different. The transition plan should also address the young person's need for good quality information about what opportunities are available and what has worked for others, including creative ways of using the personal budget.

YEAR 10 - The next review should take place during year 10 when the person is 15 and should again consider the three key questions. It should also identify the person's preferred post 16 option and consider how best to plan for this. This is

particularly important if a place in a maintained school sixth form is likely to be required to allow time for consultation, allocation and the amendment of statements by the 15th of February of Year 11.

Contact should be made by the lead worker for information and a copy of the review and transition plan should be sent to the Transition Team who should allocate the case to a transition worker.

YEAR 11 - At least three months before the review, a request should be made via the single point of access for a representative of Adult Services to attend.

The transition worker from Adult Social Care should contact the young person and their family prior to the review and arrange a joint visit with the Children and Young Person's worker to discuss the changes which will begin when the young person turns 16.

If the young person is likely to be eligible for Continuing Health Care support and funding once they turn 18, applications should be made as early as possible. It is crucial that information about the level of funding available is compiled as early as possible as this often dictates which options are available.

The year 11 review should consider again the three key questions and confirm what the person wants to do in the future. They should be offered support to complete applications for college or sixth form.

YEAR 12 AND BEYOND

This is currently the period when the person will move from children's to adults' services if appropriate for the specific individual. It is more important than ever that the person feels in control of what is happening and key to this is good communication and good quality information.

For people who are moving from children's social care to adult social care the handover process should begin in practical terms with joint meetings to build trust and allay fears, there should be no surprises or a sudden culture shock. As far as possible, funding should be agreed in advance so that plans can be made which are built around the young person's preferences and wishes.

8. ROLES AND RESPONSIBILITIES

From the start of the transition process, all services and partners have a responsibility to work together to ensure that information is shared to inform each other's assessments and that coherent planning is based on a real understanding of the young person's strengths. The specific responsibilities of each partner contribute to the comprehensive support a young person requires. Roles and responsibilities are laid out below for each partner.

EDUCATION

Schools and colleges are individually responsible for enacting their responsibilities regarding transition and the preparation for adulthood. It is their responsibility to:

- Ensure that the correct procedures are followed
- Under the guidance of the Local Authority convene and chair annual review meetings for young people with Education Health and Care Plans
- Ensure that other partners contribute to the review where appropriate
- Ensure families receive a good quality of service in Birmingham
- Identify further education needs that cannot be met locally to inform strategic planning and commissioning
- Ensure planning and reviews are child and person centred with clear outcomes

Under the guidance of the Local Authority, the school Special Educational Needs Co-ordinator, in conjunction with the head teacher, organises statutory annual reviews for all those young people with EHC Plans, at a time, wherever possible, convenient for the young person and parent /carers. Transition planning is incorporated in these reviews. SENCos provide information to the SEN Education Service about who has an EHC Plan or is receiving SEN Support which will be reviewed regularly at least once a year.

Educational psychologists offer psychological services to schools, young people and their families and work in partnership with individuals, groups of children and other adults in the community to promote positive outcomes for children.

For children and young people educated at home it is the responsibility of the local education authority to convene the annual reviews.

In general, funding for schools is based on any additional provision which may be hours, equipment etc as set out in the young person's Education Health and Care Plan.

HEALTH

Health professionals working with young people with additional needs are responsible for:

- Ensuring that reports are provided for the Year 9 annual review and subsequent reviews as required where a young person has significant health needs which need to be considered in transition planning.
- Ensuring that they attend annual reviews where a young person is likely to need health care support on leaving school, in order to advise on how the young person's health needs may impact on future placements
- Offering to provide Health Action Plans which identify appropriate ways of meeting the health needs of the young person and ensure that these are developed in Year 10 and 11 and updated in subsequent years for young people who stay in education post 16.
- Facilitating the transfer to Adult Health Care Services and ensure that referrals to relevant services are made in good time so that there is no gap in service provision and that the young person has a registered GP.
- Ensuring that young people and their parent/carers know when and how this transfer will take place and that sufficient warning is given.

- Working with the relevant Clinical Commissioning Group to resolve any difficulties about responsibility for the provision of health services which may arise in the case of young people placed outside of Birmingham in non-maintained or independent schools.
- Ensuring that health assessments are undertaken, and referrals presented to the relevant professional well in advance of the transfer, informing partners working with the person of any decisions taken including joint funding arrangements.

Health Pathways include: -

- Child and Adolescent Mental Health to Adult Mental Health
- Speech and Language Therapy
- Physiotherapy
- Occupational Therapy
- Acute Transition Pathway
- Palliative Care Act Pathway
- Continuing Care Transition Pathway

Planning transition from children's to adult health services should form an integral part of the broader transition planning and link closely with transitions in education and social care.

School Nurses have a key role to play in ensuring good co-ordination between Health Professionals and the Local Authority in relation to transitions. They have a role in acting as a 'gateway' or point of access in the review process with the wide range of health pathways including those set out above.

School nurses are the key liaison point for Health in transition planning - the school will work with the young person, family and school nurse to identify whether the young person is likely to continue to have health needs when they leave school/turn 18 years old. School Nurses are responsible for identifying a health care plan for young people with complex needs. Although they will not necessarily attend reviews, school nurses are a point of contact for all health issues and should liaise with the young person's keyworker in transition.

Where the young person has significant health needs the EHCP annual review will require attendance from the school nurse or an Allied Health Professional or a paediatrician. The following process ensures that health professionals are involved on a needs led basis, using the different levels of input set out below. Following this the Headteacher will arrange invitations.

- Universal - Health input by school nurse into the transition process by sharing of core information with the Headteacher to share with the family

- Targeted - For those with health needs set out in health care plans, there will be direct liaison with the school nurse who will input into the annual review meeting based on the current health care plan to ensure a smooth transition
- Specialist - For the minority of young people with severe or complex health needs requiring additional health transition support, the most appropriate health professional will attend the young person's review
- Parent/Carers and young people are informed in advance of the meeting who has been invited and who will be attending the end of year review

CHILDREN'S SERVICES

Social Workers are involved in undertaking assessments of children and young people in need and their families under the Children's Act, 1989. The assessment framework is used in a variety of ways to carry out assessments on a range of areas. This includes assessments for access to:

- Short Breaks
- Safeguarding children and young people
- Family Support Services
- Aids and Adaptations/Assistive Technology
- Any Service provided by social care teams

Disabled children and young people with social care needs will be allocated a social worker from the Disabled Children's Team or a Children's Locality Team if they are subject to a child protection plan or are looked after. Team Mangers in these teams should ensure that a social worker attends the year nine annual review meeting and contribute to transition planning where a young person is subject to a care order, accommodated by the local authority or is in receipt of a service.

If young people have a need for adult social care but do not meet the eligibility criteria for the Transitions Team, they will be referred through to adult services.

Children's Services staff should undertake the following responsibilities throughout the transition process:

- Fully involve the young person and, where appropriate their family, in the transition process
- Consider the need for advocacy involvement or peer support
- Promote independence and choice based on child centred planning
- Inform Adults Services of any potential safeguarding concerns that will be ongoing
- Notify the Adult Social Care Transition Team at the age of 14 of all proposed placements/support packages that may require Adult Social Care funding post 18 prior to making any formal agreement. This is due to the difference in eligibility criteria

- Participate in multi-disciplinary meetings to ensure the transition is streamlined and seamless
- Escalate disputes using the agreed governance arrangements

ADULT SOCIAL CARE TRANSITIONS TEAM

Transition social workers should fulfil the following responsibilities throughout the transition process:

- Fully involve the young person
- Consider the opportunity for advocacy/peer support
- Consider the opportunity for Assistive Technology
- Engage in timely discussions with children's services from the age of 14 to ensure that all necessary planning and funding agreements are completed in good time, enabling the transition to be as seamless as possible for the young person and their family
- Promote independence and choice and ensure the young person is supported to maximise opportunities in relation to education, employment, housing, health and community connections
- As required by the Care Act, Adult Social Care will carry out a Child's Needs Assessment for young people who are likely to have needs for care and support after they reach 18. The purpose of this is to determine what adult social care a young person might be eligible for once they reach 18 so that they can make informed choices about their future. The assessment can be requested at any time prior to the young person's 18th birthday whether or not they have an EHC Plan and will be carried out at a time when it is of 'significant benefit' to a young person's preparation for adulthood and should include what their future support might look like
- At a date to be agreed with the young person and their parents/advocate, Adult Social Care will by no later than the persons 17th birthday (and earlier where agreed significant benefit will be achieved) work towards developing the EHC plan to include outcomes enabling the person to consider their educational and or work and accommodation options. A personal budget will be calculated enabling planning to start. Consideration will also be given to what the Adult Social Care financial contribution for those eligible under the new eligibility criteria will be

- For those who wish to remain in education, Adult Social Care will continue to work with children's services colleagues and the young person to develop the EHC plan which shall be the planning tool used to meet the Care Act requirement to complete an assessment and produce a Care and Support Plan
- For those not entering into or leaving education Adult Social Care will work with the young person to produce a care and support plan which will include a provisional budget and outcomes
- A Carers assessment will be undertaken where requested or where it appears the carer requires additional support.

9. THE BIRMINGHAM APPROACH

The Birmingham approach to transition and preparation for adulthood to ensure the roles and responsibilities outlined in our protocol are maximised across the whole system, the vision is realised and the principles are applied is the adoption of a flexible relationship based model between partners which does not revert to silo working.

The law makes it very clear that there should not be a 'cliff edge' approach when someone reaches 18 and that services for children should not stop until adult services are in place.

Young people with SEND may face additional difficulties in transferring between long standing services they have accessed as children and potentially now adult services, if appropriate and required, calling for the building of new professional relationships. Young people should be introduced to adult services staff at the age of 14.

Decisions about further education, employment, community involvement and accommodation will need time to consider and commission. Early referrals between services, annual transition planning meetings and reviews will help reflect changing needs and identify what is working and what is not.

Adult health and social care services provision will focus on those social care services which support young people to live more independent lives and ensure that young people are given every opportunity to engage in services through regular contact.

It is important that key partners such as housing providers, education providers, schools and colleges, Early Help and employment providers work closely with statutory health and social care colleagues, as supporting successful transition has to be a shared responsibility.

KEY WORKING

The transition process attempts to underpin a structure of pre-determined roles and responsibilities across agencies, involving key professionals in the transition planning process. However, the Birmingham transition protocol whilst outlining roles and responsibilities which is important in relation to accountability, subscribes to the view that individual professionals should seek an expansive view rather than a limited role based on the concept of key working.

Key Working here defines a way of working rather than its traditional meaning of identifying a principal professional for co-ordinating a young person's support. Whilst this can be a facet of key working, the use of the term here envisages professionals taking a wider perspective of their involvement which is outside of their sometimes narrow professional role with the aim of being able to recognise that it is everyone's job to seek the best possible outcomes for each child.

To do this, Key Working calls for the professionals to adopt a set of behaviours and practice aimed at building strong and resilient families, by ensuring that their practice includes:

- Co-production, this means listening to young people and their parents and ensuring that they participate fully in the transition process
- Young People and families being able to live ordinary lives
- All assessments being integrated or aligned
- Ensuring transition support is developmentally appropriate taking into account the person's maturity, cognitive abilities, psychological status, long term conditions, social and personal circumstances, caring responsibilities, communication needs
- Ensuring transition support is strength based and focuses on what is positive and possible for the young person rather than a set of pre-determined transition options
- Person Centred planning which gives young people a chance to say what their hopes and dreams are from a personal perspective, and that they are treated as an equal partner
- Young people and their families having informed choices
- Providing accessible and clear information
- Relevant information sharing which is not bound by preconceived ideas of the requirements of data protection rules
- Safeguarding information should be shared as appropriate by all partner agencies in line with local policy
- Problem solving and learning from recognising that there might be different views but that fundamentally everyone is working together to seek creative solutions which put the young person's benefit at the heart of the process to prepare them for adulthood
- Support after transition and evaluation of the transition journey and impact on the young person's life goals

10. PERFORMACE MANAGEMENT AND GOVERNANCE

GOVERNANCE

Young people, parent/carers and professionals will meet on a regular basis via several stakeholder forums, such as the YES group and Parent & Carer Forum, to ensure that the process of transition planning continues to develop and improve.

PERFORMANCE MEASURES

Preparation for Adulthood is part of the infrastructure and governance which fundamentally ensures that there is a systematic 'line of sight' to practice through to the individual cases.

Ownership by senior leadership and their consistent messages to staff at all levels will drive the necessary improvements required. Performance will be reported to the operational Preparation for Adulthood Board and strategic Life Course Board on a monthly basis.

In simple terms when professional jargon is stripped away, preparation for adulthood and life means generally preparing for: -

- Independent living and housing
- Employment/Education/Training
- A healthy life
- Friendships/relationships/community connection

In addition to the statutory services included in this Protocol, much work is being undertaken across the whole system to support young people as they transition to adulthood. The two-year proof of concept is one example of such work. It was felt that, in order for the Strategy and Protocol not to date, that all work on transitions be captured via a link to Waiting Room and Connect to Support which is the Adult Social Care Information, Advice and Guidance website. This website is split into 3 broad sections: information and advice, groups & activities and products & services. The site was refreshed last summer and now hosts the NNS community directory which is an excellent reference point for services and citizens alike to access information. Having the information on the website enables it to be regularly updated to provide stakeholders with the most current information.