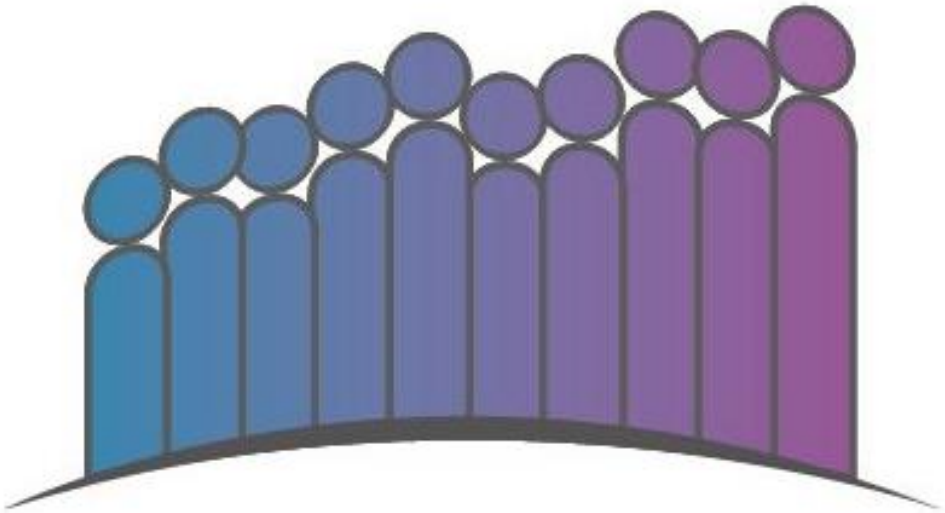
Transition Protocol

Supporting the transition of young people with special education needs and disabilities from age 14 (year 9) to adulthood

Information for parents and professionals



Hull Childhood to Adulthood Person Centred Transition Protocol

Introduction

This protocol aims to help Hull Special Educational Need and/or Disability Services (SEND) and other services within the Children, Young People and Families Directorate, Adult Social Care, Hull CCG and other NHS partners work together with families and young people to achieve the best possible outcomes for young people as they approach, and live through, their transition from childhood to adulthood

The protocol aims to bring clarity to the purpose and roles of the diverse range of organisations and agencies that need to work together in the interest of young people and their families

This protocol has been co-produced with contributions from parents, and comments from young people

All young people and their representatives should be able to access advocacy which is appropriate to their needs where it is necessary to enable them to fully participate in transition planning or to access the information available through the local offer and Hull Connect to Support to enable them to make informed choices

Scope

This Transition Protocol applies to all young people from age 13 upwards who are formally recognised as having Special Educational Needs, whether or not they have an Education, Health and Care Plan (EHCP). Where someone does have an EHCP plan, procedures are more detailed due to the requirements of the Code of Practice and the number of agencies likely to be involved. All national guidelines have been followed in developing this protocol

1. The role and commitments of different agencies for young people with Education, Health and Care Plans (EHCPs)

All agencies involved will identify a lead officer for transitions to act as a point of contact, and who will be able to direct young people, their families or other professionals to the relevant team or person if issues arise which cannot be resolved through the transition process or if the transitions process has been delayed or interrupted. They will also be able to direct people to sources of information and advice available to young people, parents and staff about the transitions processes and pathways. They will provide reports as necessary about good practice, issues and concerns to the Transitions Strategic Group so that good practice can be shared, issues resolved and lessons learned.

1.1 The transitions lead officer's role will be to:

- Support the dissemination and growth of best practice for everyone involved in transition from children's to adult services
- To support and advise team/service area colleagues on transition matters
- Act as a resource and a point of contact for colleagues who require support and guidance on transition issues

- Cascade/disseminate transition information received to colleagues within their teams
- Support staff in identifying those at risk of harm or those at risk of support breakdown and assist in their understanding of the action they need to take
- Maintain up to date knowledge of transition issues including the referral processes to be followed internally within the organisation and when raising concerns with partner agencies
- Encourage colleagues to recognise and be aware of trends and themes within their area so these can be fed back to the Transitions Strategic Group
- Make sure transition practice complies with the legislation, policies and guidance of their organisation

1.2 The Named Worker in the transition planning process for individual young people and their families

All young people who require integrated support from more than one practitioner should experience a seamless and effective service in which one practitioner takes the lead to ensure that support is coordinated, coherent and achieving intended outcomes

The Named Worker should act as the single point of contact for all professionals providing support to a young person. They should coordinate the actions agreed at Transition Planning meetings and Annual Reviews, progress chasing where necessary. Named Workers are responsible for their own service's input; they are not responsible for the actions of other practitioners or services. If actions agreed by or allocated to other service areas are not being taken in a timely way, the named worker should raise the issue with the transitions lead officer for that area.

Young people (and their family where relevant) will be consulted on who their Named Worker is by the Special Educational Needs Coordinator (SENCo) or named person with responsibility for SEN if post 16. Where possible, the worker should already be known to the young person and their family, should have the necessary knowledge and skills and have the workload capacity to discharge the role.

In the majority of cases where a young person has an Education, Health and Care Plan for special educational needs, a Connexions Senior Participation advisor will take the Named Worker role from year 9 onwards. However, other people may be better placed to take on the role, for example:

- Pre-transition, where an Initial or Core Assessment is being carried out under the framework for the Assessment of Children in Need and their Families (2000), the responsible Social Worker shall be the Named worker during the assessment period
- Where a young person is subject to a Child Protection Plan, or where the young person is Looked After or where adoption is the plan for the young person; the named Social Worker is responsible for acting as the Named Worker
- Where the young person is a care leaver and is an "eligible child" under the Children (Leaving Care) Act 2000, they will have a named Social Worker who will assume the role of Personal Adviser and will, therefore, be the Named Worker.
- Where the young person has a learning disability or mental health needs and a Care Programme Approach is being followed; the Care Coordinator will be the Named Worker from Humber Foundation Trust
- Where young people are subject to community orders or sentences, the Youth Offending Team will allocate a Supervising Officer who would normally be expected be the Named Worker

2. Schools and Education, Health & Care Plans (EHCP)

An education, health and care (EHCP) plan is for learners aged up to 25 who need more support than is available through mainstream special educational needs (SEN) support. It is a legal document that is written by the Local Authority (LA). The plan will outline the type of support or intervention that the learner will receive to ensure that their needs are being met.

Where it is felt that an EHCP is required to support a learner a request for an Education, Health and Care Needs Assessment can be made either by the parent of the learner (if the learner is under 16,) or the young person themselves if they are post 16 either independently or in collaboration with the education provider. Where a request for an EHC Needs Assessment is made collaboratively the SEN Coordinator (SENCo), or designated person should invite all relevant parties to an initial meeting to support the completion of the Education Health and Care Needs Assessment Request documentation. As part of this meeting, information detailing the learner's needs and the support which is currently in place to support them will be discussed and included in the request along with some initial thoughts from the learner and their parents.

With consent, this documentation will be submitted to the LA SEND Assessment and Review Team and this in turn will be shared and discussed by the moderating group. From the moderating group discussion the LA will make a decision on whether to carry out an EHC Needs Assessment.

If it is agreed to carry out an EHC Needs Assessment further input will be sought from all professionals involved with the learner including health and social care as well as an Educational Psychologist and the learner themselves and their family. Once all the relevant advice has been gathered the moderating group will consider all the advice and the LA will decide on whether to issue an EHCP or not.

If an EHCP is agreed then the young person's long term aspirations should be set out in Section A of the EHCP, the steps taken in order to work towards these aspirations can then be agreed and written as outcomes which are Specific, Measurable, Attainable, Realistic and Timetabled (SMART) and set out in section E of an EHCP. The SEND code of practice directs this as follows:
'Long-term aspirations are not outcomes in themselves – aspirations must be specified in Section A of the EHC plan. A local authority cannot be held accountable for the aspirations of a child or young person. For example, a local authority cannot be required to continue to maintain an EHC plan until a young person secures employment.' (S9.65)

If outcomes require the input of other agencies or teams to achieve them, the agreement of these agencies must be obtained before a plan to achieve the outcome can be agreed. Provision required support identified educational needs which is to be provided by education will be detailed in section F of an EHCP, provision required to support Social Care needs and to be provided by social care will be detailed in section H1 and/or H2. Provision to meet health needs will be detailed in section G, in agreement with the health commissioner.

3. Preference for a Particular Setting

Once an EHCP is in a draft format or the Local Authority has agreed to amend a current EHCP the SEND team will seek the preferences from parents or young person on the educational setting they wish to attend. The wishes of the young person and

their family will be met where possible but Hull City Council will always try to place people locally (within the city boundary or as close to it as possible.) The report of the investigation into the events at Winterbourne View, Transforming Care, highlighted the difficulty of monitoring the quality and safety of out of area provision and requires that wherever possible, a person's needs should be met locally. This is in keeping with the SEND code of practice s7.13 – 1.17, and the Equalities Act and provides a number of important benefits to the young person and their family:

- The ability of the local authority to closely monitor the effectiveness of the provision means that it can be readily adjusted if the young person's needs and wishes change as they mature.
- The ability of the local authority to closely monitor the quality of the provision means that any lapses in quality which infringe the person's rights or constitute abuse can be immediately addressed and remedied.
- Local provision supports the young person to develop appropriate social and community networks, and to better maintain familial relationships.

If local providers cannot meet the young person's needs, Hull City Council will support them to put in place the necessary special educational provision to meet the additional needs set out in the individual's EHCP.

Out of area placements can only be considered if the young person's needs cannot be met via local provision. The local authority will only consider placing people in specialist educational placements where this meets the requirements of s7.3 of the SEND code of practice that such placements are suitable for the young person's age, ability, aptitude or SEN, and that to place the young person there is compatible with the efficient use of resources and the efficient education of others.

4. EHCP Annual Reviews

Once an EHCP has been finalised this must be reviewed at least annually. An EHC Annual Review is completed once the Local Authority have communicated their decision to Maintain, Amend or Cease the plan. Where learners are on the role of an education setting the SENCo (or designated person) will organise annual reviews of the EHCP.

EHCP annual reviews should be person centred, include the young person, and should use and promote the use of person centred planning tools.

The date of an EHCP annual review meeting should be agreed in advance with young people, their families and all contributing agencies to ensure as many relevant people attend as possible. Where ever possible invites to an EHC Annual Review should be sent out in sufficient time to allow all professionals to be able to attend. If the young person needs the support of an advocate to enable them to participate, this should be commissioned by the relevant CYPFS team

The SENCo (or designated person) will invite all relevant agencies to the Annual Review meeting. SENCo's should check with the young person / family who they would like to invite.
As stated in S9.176 of the SEND Code of Practice the SENCO must invite:

- The Local Authority SEND Team
- Representation from the education provider
- Health Services

- Local Authority Social Care

Invites to annual reviews for Adult Social Care can be shared through highneedsteam@hullcc.gov.uk

The SENCo should also invite other individuals relevant to the review, this could include:

- Any other relevant teachers or tutors
- Connexions Senior Participation Advisor
- Other Educational outreach services as appropriate e.g. Integrated Physical and Sensory Service (IPASS)

All agencies contributing to the EHC Plan should provide up to date information about progress towards outcomes along with any changes to need or provision and how this will be supported. The organiser of the Annual Review must circulate all reports to inform the EHC Annual Reviews at least 2 weeks in advance of the Annual Review meeting to allow everyone to be familiar with their content.
In addition to a review of progress towards the outcomes in the EHCP, the review meeting should also ensure that the Special Educational Needs and support detailed in the EHCP remain accurate and appropriate.

Following the annual review meeting, the SENCo must ensure that the Annual Review report is completed on the relevant LA documentation and sent, along with any supporting reports or documentation, to the SEND Assessment and Review Team and all involved in the process. This documentation must be sent to the LA SEND team within 2 weeks of the Annual Review Meeting.

4.1 - Year 9 Annual Review

From Year 9 onwards the Code of Practice (2015) clearly states that all annual reviews should have a focus on preparing for adulthood.

"Local authorities must ensure that the EHC plan review at Year 9, and every review thereafter, includes a focus on preparing for adulthood. It can be helpful for EHC plan reviews before Year 9 to have this focus too. Planning must be centred around the individual and explore the child or young person's aspirations and abilities, what they want to be able to do when they leave post-16 education or training and the support they need to achieve their ambition." (Pg 125, S8.9)

As part of the Year 9 Annual Review the young person's long term aspirations should be reviewed to make sure that the focus is now on their aspirations for their adult life.

These should be reflected in any recommendations to amend Section A of the EHCP. In addition the review should begin to focus on preparation for adulthood and other transition matters. The development of life skills should be supported from an early age but preparing for adulthood must be a particular focus from year 9 onwards.

Support to prepare for adulthood should include four key themes:

- Further or Higher Education and/or Employment
- Decision making and Independent Living
- Maintaining Good Health
- Participation in Society and Friendships

From Year 9 onwards annual review meetings should also provide an opportunity to explain the changes in legislation which take place when the child/young person reaches 16, preparing parents for the fact that under the Mental Capacity Act that from the age of 16 their child will be assumed to have mental capacity and able to make decisions independently about their future provision. Alongside this steps should be taken to prepare the young person to make decisions about their future should they wish to.

Young people and their parents should be given good quality information about the Mental Capacity Act which begins to apply when the young person turns 16 and be supported to access training in the application of the Act where possible. As a minimum, the information should set out the principles of the Act, the assessment of capacity, the Best Interest decision making process and the Deprivation of Liberty Safeguards (soon to be superseded by the Liberty Protection Safeguards.
There is not a widespread understanding of the Mental Capacity Act and how it should be used and so the information provided should seek to allay fears as well as clarifying the terms of the Act.

The young person's health and social care needs should be considered and if it appears that the young person may have health or social care needs which extend into adulthood, referrals should be made to the relevant adult health and social care teams. Copies of Adult Social Care referrals can be made by Children's Social Care teams, SENCos or other colleagues and should be sent to the Transitions Co-ordinator in the High Needs Team by contacting: highneedsteam@hullcc.gov.uk

4.2 - Year 10 Annual Review

The annual review of the EHCP which is completed in Year 10 should begin to focus on the preferred post 16 option / provision. Preferences for Post 16 provision should be communicated with the Local Authority SEND team through the phase transfer process in the second half of the summer term of Year 10 or the autumn term of year 11. This is to allow appropriate time for consultation, allocation and the amendment of Education, Health and Care Plans by 31st March of Year 11.

Adult health and social care teams who are likely to be involved in supporting the young person after they reach adulthood should attend Year 10 annual reviews and clarify how they will support the young person. This should have been agreed during the assessment and support planning undertaken during Year 9. Any amendments to social care support plans which are requested cannot be made at the EHCP annual review meeting but must be referred back to the relevant adult's health or social care team to ensure consistency and equity for all adults needing support.

Consideration should also be given at this time to any current transport needs and how these can be supported moving forward, giving due consideration to the information detailed below regarding transport.

Transport

It is important to note that, in keeping with the SEND code of practice s9.214, the young person's family may be expected to meet the cost of transport, where the child or young person's needs can be met at an educational setting closer to their home than the setting of preference. Where a young person is out of statutory education and

no longer eligible for transport to and from an education setting, the SEND team would be advising the use of a PIP payment to support transport to an educational setting.

It is also important to note that although the Adult Social Care (ASC) department can provide assistance with transport in some limited circumstances, this is only when there is no reasonable alternative and only 'to and from' support services identified in the social care support plan to meet duties set out in the Care Act.
If the young person does not have a support plan because they do not have eligible ASC needs, or if the education provision is not identified in the ASC support plan as necessary to meet eligible ASC need, the Adult Social Care department will not be able to provide assistance with transport. If the local authority has a duty under the Education Act to provide assistance, other sources of support or funding must be sought.

4.3 - Year 11 Annual Review

The annual review in Year 11 can be used to inform applications to post 16 provision and other processes such as the SEN transport application. For this reason where an EHC Annual Review does not fall in the autumn term of Year 11 or the final half term of Year 10, an additional review will be required to support phase transfer consultations to be complete by 31st March of Year 11.
Where an annual review falls in the second half of the summer term the Year 10 review will be used to inform consultations and then the Year 11 annual review will be held as usual inviting the post 16 provider to support transition.

If the young person has health or social care needs which are likely to extend into their adulthood, formal needs assessments and support planning will take place to inform the agreement of a formal transition plan. The transition plan will cover all aspects of a young person's life including: education, training, personal support, health, wellbeing, leisure, housing, and community inclusion (including relationships). The wishes and best interests of the young person must be central and all those involved must have regard to them. In addition, the young person's needs must be met in the way which is least restrictive of their rights and freedom.

The education and skills act (2008) raises the participation age so that all young people leaving Year 11 are required to continue in education or training until at least their 18th birthday. This does not necessarily mean that the young person has to remain in school and participation can include:

- Full time study in a school, college or with a training provider (540 hours of planned learning which equates to approximately 18 hours a week dependent on the length of the academic year)
- Full time work or volunteering (20 hours or more) combined with part time education or training or
- An apprenticeship or traineeship

4.4 - Year 12 and beyond

As per Year 9, the planning for transition to Adult Health and Social Care support (where appropriate) should begin when the young person reaches age 14. If this process has not already begun, it needs to happen with some urgency. In addition, the ASC Transitions Co-ordinator should be notified by professionals working with the

young person that a delayed transition has occurred by contacting highneedsteam@hullcc.gov.uk

When the young person turns 18, responsibility for meeting their health and social care needs will transfer to the relevant ASC teams. The young person's needs will be assessed under the national eligibility framework for Adult Social Care and any support plan will be agreed with the young person and their family. If the young person needs the support of an advocate to enable them to participate, this should be commissioned by the relevant Adult Social Care team

If an EHCP remains appropriate there is a requirement for the Local Authority to continue to maintain the EHCP.

An EHCP can remain until the young person reaches 25 if they have been unable to achieve the agreed outcomes and it appears that ongoing educational support will enable them to do so. However, this will be the exception rather than usual practice. The EHCP can only cease if the young person requests in writing that the EHCP is no longer required or if the Local Authority deem that the young person no longer needs it, for example, following a review the education outcomes detailed in the plan have been achieved and the young person no longer needs additional educational support

Where young people are educated other than at a school, college or training provider the procedures are generally the same as described above, however it is the Local Authority SEND Assessment and Review Team that has responsibility for organising and chairing the reviews. This responsibility will be supported by the named worker.

5. Connexions

Connexions offers an impartial client-centred careers information and guidance service. The staff are trained to offer confidential advice and practical help relating to a wide range of issues including Special Educational Needs and/or disabilities (SEND).

Some schools may employ their own careers advisor. The Local Authority are not able to comment on the quality or impartiality of advice from such individuals due to working independent of Hull City Council.

Connexions provide a core offer of advice and guidance to young people with a Hull EHCP which can be accessed by all city schools. The Connexions service can be contacted by email to Fiona.Arnott@HullCC.gov.uk

5.1 The Connexions service will:

- Allocate a named Connexions Senior Participation Adviser to work with each young person from age 13 upwards (including those who are home educated, or off-school role) and provide advice and guidance on post 16 options and who will normally act as the named worker for most young people).
- Carry out a pre-review or post review discussion with the young person at Year 9 and attend each review from then onwards
- Draw up a written report summarising their discussions with the young person, what the young person's future aspirations are and what action needs to take place in order fulfil those aspirations. This report should be included within the documentation informing the EHC Annual Review.
- Connexions can remain involved with a young person with a Hull EHCP from Year 9 up until the plan is ceased.

6. Hull City Council Special Educational Needs and Disabilities (SEND) Team

The SEND team's core responsibility is to issue and maintain Education Health and Care Plans (EHCPs) for young people aged 0-25 who have been assessed as requiring it, following statutory guidance laid down in the SEND Code of Practice issued 2015

Hull City Council Special Educational Needs and Disabilities (SEND) Team will:

- Be responsible for the Annual Review process, ensuring that any requests for amendments to the EHCP are considered
- Communicate decisions to parents/carers or the young person on whether to maintain, amend or cease an EHCP within 2 weeks of receipt of the Annual Review documentation
- Monitor the timeliness of Annual Reviews and provide reports on completion rates for the Annual Performance Assessment

7. Local Authority Children and Families Disability Team, and Children's Social Work teams (ILAC and Localities)

The Children & Families Disability Team offers support to children and families who are significantly affected by disability. Services are targeted in a way that promotes family life, individual needs and the rights of the child. The team works collaboratively with key partner agencies in health and education to reduce disadvantage and promote care and support. The team accesses a range of provision from both the Local Authority and the private sector, which enables them to provide a flexible response to individual family needs

7.1 The Local Authority Children and Families Disability Team will undertake the following:

- If the child / young person has an allocated social worker from the Children and Families Disability Team, when invited, they will provide a report for, and attend, all EHCP reviews
- If a young person is receiving commissioned services, and it appears likely that the person will be eligible for health or social care support, post 18, the child's social worker will inform the Transitions Co-ordinator, on the High Needs Team who will ensure the statutory assessments and support planning take place in a timely fashion to facilitate continuity of care where this will be required. The HNT can be contacted via email highneedsteam@hullcc.gov.uk
- The referral to Adult Social Care services for the age 14 review must be made at least 6 weeks prior to the review and the date of the review should be agreed in advance by all parties.
- If a child or young person is 'Looked After' their social worker will (if appropriate) maintain links with the child/young person's family
- Make sure that Looked After young people over the age of 14 have a pathway plan which has been established via an assessment
- Looked After children/young people will be given extra support to think about their options regarding their living arrangements, continuing their education and employment as they make their transition into adulthood

- Work with colleagues to embed new sustainable practices in the CYPFS social work teams
- Monitor and respond to training issues as they arise.

If a young person at age 14 is receiving a care and support package that includes health funded provision, a referral must be made to the Complex Commissioning Transitions Group. This can be done directly or via the High Needs Team by email highneedsteam@hullcc.gov.uk

If a young person is looked after in one of the Local Authority's children's homes or an externally commissioned children's home placement, and appropriate move-on provision has not been identified by the young person's 16th birthday, an immediate Children's Transition meeting should be held to consider future need and eligibility and to refer the young person to the appropriate Adult Health and Social Care teams who will carry out assessments, determine eligibility for ASC support and where such eligibility exists, begin to formulate plans for adulthood. If the 'Looked After' child does not have eligible health or social care needs, responsibility for meeting their needs will be retained by the CYPFS Leaving Care Team.

Note - It is important to note that for every young person who may be eligible for Adult Social Care support at age 18, in any form, the following referrals must be made to:

- The Health Complex Care Panel age 14 if there are likely to be health care needs
- The Transitions Co-ordinator at the ASC High Needs Team at age 14, especially if their social care needs are complex

Failure to do so at the correct time may mean that suitable planning cannot take place, leaving the young person and their family at risk of a lack of continuity or breakdown of support

Direct Payments

Where a young person has been in receipt of Direct Payments funded by Children, Young People & Family Services (CYPFS), the payments will be considered as part of the young person's transitions plan. This transitions plan will include the way in which payments via a Direct Payment method may or may not change. Direct Payments for adults can be made to people willing and able to manage them to purchase support which meets eligible health and social care needs as outlined in the support plan.

8. The Leaving Care Team

The Leaving Care Team will follow the statutory guidance applicable to young people leaving care.

For young people who are subject to Leaving Care arrangements and have an EHCP, the processes outlined in this protocol will apply. If this has not been achieved, and it appears the young person may have eligible needs for Adult Health or Social Care support after the age of 18, the Leaving Care Team will refer the person to the relevant teams and the HNT Transitions Co-ordinator at the earliest opportunity.

The ASC teams and the Leaving Care Team will jointly consider (following a statutory assessment of need by an Adults Social Care worker), how the person's needs may be met post 18.

9. Special Educational Needs Information, Advice and Support Service (SENDIASS) provided by KIDS

SENDIASS is a free impartial and confidential service. They can offer support and advice to parents/carers in Hull who have a child aged 0-25 years with a Special Educational Need and/or Disability. Support can also be provided directly to young people themselves if required

9.1 SENDIASS will help to explain the following to young people and families engaged in transitions:

- The SEND process including assessment and provision
- Parents/carers and young people's roles and rights
- Professional reports
- Educational options and choices
- The roles of other agencies
- Personal budgets and the Local Offer
- Support to help parents/carers and young people make appropriate and informed choices

Support can be provided via telephone advice, home visits, meeting in schools and with other agencies. Help is also available with letters, referrals to other agencies and support with regards to appeals and complaints.

A SENDIASS practitioner is provided by KIDS for young people up to the age of 25. KIDS also provide a specialist advocacy service for young people up to 19 years old who are living in residential setting or care settings including foster placements.

Contact details for these services are:

Address: KIDS, 182 Chanterlands Avenue, HULL HU5 4DJ
Tel: 01482 467540
Email: enquiries.yorkshire@kids.org.uk

10. Hull Youth Justice Service

Youth Offending Teams (YOTs) are responsible for the supervision of children and young people aged below 18 years who are sentenced by a court, in line with the Youth Justice Board's (YJB0 National Standards for Youth Justice Services and YJB Case Management Guidance). When someone under the age of 18 is sentenced to custody, the YOT will inform the local authority. If the person has an EHCP, the local authority will forward it to the YOT. The standards and processes set out in this protocol will then be followed.

10.1 YOTs are required to follow the minimum standards identified in this protocol. The YOT will:

- Ensure that all young people have access to education, training or employment
- Refer to relevant services, where the young person appears to have additional health and social care needs or special educational needs.

- Attend meetings to share information about risks and needs and plan for transitions
- Where the young person has additional health and social care needs which are eligible for support by ASC teams and which will be met by those teams when the young person turns 18, the YOT will consult and work with the young person and their family/carer to inform them of the transition process to adult education, health or social care and keep them informed at each stage
- Make sure that young people who require it, have a transition plan as soon as the need is identified and no later than when the young person reaches 17 years and 6 months
- Access to resources to enable them to work with parents of young people with SEN to help manage their offending behaviour
- Undertake specialist training in the use of visual tool to work with young people with SEN
- Positively interact with young people to increase the completion of requirements placed upon them by the courts
- Make sure that Practitioners acting as Appropriate Adult in police interviews will use appropriate language at all times relevant to needs and development
- Make sure that Practitioners will adhere to the SEND Code of Practice through the use of assessment and intervention tools which enable the participation of any young people detained in custody
- Make sure that young people sentenced to custody or remand are assessed to identify any needs and that this information is shared with the custodial case manager
- Make sure that when transferring cases to the National Probation Service or the Community Rehabilitation Company that all relevant information about their needs is shared
- Make sure that where young people detained in custody have a EHC plan, this is shared with the custodial establishment and forms part of the young person's sentence plan

11. Adult Social Care

Adult Social Care describes the support provided to people aged 18 and over to enable the local authority to fulfil its duties under the Care Act. Hull City Council's Adult Social Care department fulfils some of these duties directly and has delegated its specialist learning disability and mental health social work teams, to the Humber Teaching Foundation Trust (HTFT) through a Section 75 agreement with the Clinical Commissioning Group (CCG), therefore, this section of the protocol only deals with non-specialist 'Locality Team' social work. For specialist learning disability services please see the section on Humber Teaching Foundation Trust

11.1 Eligible health and social care needs

Eligible health and social care needs do not include the provision of education and this cannot be funded via Adult Health or Social Care.

Agreement to fund this must be obtained from the Education Department. If the education provider is also meeting eligible health or social care needs, then a contribution to the overall cost may be made by the relevant organisation but as this cannot include education provision, it will not cover the full cost of the education provider. If Adult Social Care is funding the social care provided by an education

provider, a financial contribution may be required from the individual, in line with the Hull City Council Adult Social Care charging policy

11.2 The Adult Social Care operating model focusses on:

- Early intervention and prevention particularly supporting the information and advice offered to citizens
- Developing a more efficient goals and actions-based Active Recovery tier
- Delivering strengths-based social work
- Developing the legal literacy of its workforce

Adult Social Care has also introduced two new innovations. A new Brokerage Service and a new Dynamic Purchasing System (DPS)

The Brokerage service aims to undertake two tasks:

- Complete Care and Support plans with people who have capacity, or non-complex cases
- Use the DPS to find a 'partner provider' who can work with the family and young person, and social workers as necessary, to develop a transitions plan, which takes into account any 247 Grids completed.

The Brokerage service needs to be accessed during the 16th year once the eligibility determination has been made and transition goals identified

The Dynamic Purchasing System (DPS) is a tool that the Brokerage team use to identify partner providers. A Pen Picture is used to share details of an individual's needs and providers then express an interest in providing support to meet those needs.

A number of providers may then be engaged with (depending upon the level of interest), and more detailed plans developed with the ASC workers, family and young person.

The DPS can be used any number of times until a suitable provider is finalised and works best when it is accessed early (age 16) for transitions cases

11.3 The provision of Adult Social Care support

Options for the provision of Adult Social Care support in adulthood (post 18) will be identified via the ASC Brokerage team and will always include the offer of a Direct Payment if the young person is able to manage it or has someone available, willing and able to do so.

11.4 Adult Social Care will follow the standards of this protocol and will undertake the following:

On receipt of a referral for a case at age 14, the ASC High Needs Team will facilitate a joint ASC and CYPFS Transitions planning/review meeting with the family and young person. This transitions planning meeting will take place during the young person's 14th year.

At the joint ASC & CYPFS planning/review meeting with the young person/family/carers, a CYPFS social worker and ASC worker will attend.

The ASC worker will discuss the Mental Capacity Act 2005 and the Care Act 2014. The meeting will identify the implications for the young person and their family/carers, with specific emphasis of the Care Act on independence, wellbeing and the three-stage eligibility assessment for ASC services.

The ASC worker will also outline how mental capacity is assessed and the Best Interest decision making process for people who lack capacity to take specific decisions.

Note - Appendix 1 covers the key concepts and principles for more detail on capacity assessments and Best Interest decision making.

The family and young person will be introduced to a care and support planning tool which supports, through a process of gradual change, the growth of independence and wellbeing. Full training and support will be provided to all parties involved. If the young person needs the support of an advocate to enable them to participate, this should be commissioned by the relevant ASC team.

If a young person has health and social care needs at age 14, a referral must be made by the CYPFS social worker to the Complex Commissioning Transitions Group which oversees the coordination of health and social care provision for young people with complex health and social care needs and assist with:

- Support, compilation and maintenance of the Transitions Tracker
- Offer legal literacy training on key aspects of ASC law, and training on this protocol, to CYPFS social workers, young people and families so that all social work staff across both directorates are better able to meet legal obligations
- Promote use of and access to Connect to Support and the Local Offer
- Promote use of and access to the Social Prescribing service
- Promote use of the Carers Information Support Service (CISS)
- Enable access to Independent Care Act or ‘process’ advocacy (ICAA) and or specialist Independent Mental Capacity Advocacy (IMCA) or Independent Mental Health Advocacy (IMHA) as suitable
- Make sure that, for a young person who is referred to the High Needs Team at age 14, that a statutory assessment is completed within 6 months of the young person turning 16

11.5 Adult Social Care – Summary

Output of the joint meeting at age 14 will be:

- An outline of the legislative changes as a young person ages
- Supported access to information about transitions on Connect to Support
- Information about the Social Prescribing Service, the Carers Information Support Service (CISS), and the Independent Care Act Advocacy (ICAA) provision
- Training and support to use the 247 Grid planning tool for greater independence and wellbeing in adulthood
- An agreed date for an age 16 review, at which the statutory social care assessment will be completed and the allocation of an ASC worker for the young person

At the age 16: the High Needs Team will:

- Make sure an ASC worker completes a statutory assessment within 6 months; this includes any referrals to HTFT (see below).
- Update the Transitions Tracker with details regarding the assessment and resulting eligibility determination
- Make sure that a referral is made for any eligible young person to the Brokerage team and close working is maintained between the teams
- Make sure that the Dynamic Purchasing System (DPS) is used during the 16th year once the statutory assessment demonstrates eligibility
- Make sure that 247 Grid planning tool is used by the identified provider (obtained through the DPS) in developing the ASC Care and Support plan
- Oversee the successful transition at age 18.

The Brokerage service will:

- Prioritise Transitions cases sent through to them for young people in transition from CYPFS via the ASC panels.
- Work with the ASC and CYPFS workers to facilitate an early use of the DPS at age 16.
- Use any available 247 Grids to procure a 'partner provider' by use of the DPS.

12. Humber Teaching Foundation Trust (HTFT), Adult Community Learning Disability Team and Mental Health Services

HTFT provides a very broad range of community services (including therapies), community and inpatient mental health services, learning disability services, healthy lifestyle support and addictions services to people living in Hull and the East Riding of Yorkshire.

HTFT provides specialist services for children including physiotherapy, speech and language therapy and support for children and young people and their families who are experiencing emotional or mental health difficulties and also offers specialist services, such as forensic support and support for offenders with their health

12.1 HTFT will:

- Respect the young person as an individual who is able, with support, to make choices about the care and support they need
- Support the young person and those who care for them to get the information, advice they need, and where appropriate any necessary advocacy
- Assess for eligible needs in Year 11 and where appropriate co-produce person centred care and support plans with realistic outcomes.
- Provide services and support where appropriate or signpost them to the right kind of help
- Manage the young person's and their representatives' expectations of what help they may receive from ASC
- Have an identified lead officer in all areas of Adult Social Care to deal with transition
- Learn from what works well when supporting a young person through Transition

- Attend the most appropriate meetings to support their transition from CYPFS to ASC services.
- Consider all referrals made by the Adults Panel to them within 2 weeks and provide written feedback to the panel chair on the outcome
- Complete any necessary statutory assessments within 6 months of an accepted RAM referral
- Provide an appeals process should the decision on acceptance be disputed
- Accept referrals from the Adults Panel or High Needs Team for young people age 14 and over, providing written responses to the Adults Panel or High Needs Team to all referrals made
- Accept referrals from the Health Complex Care Group for young people age 14 and over, providing written responses to the Health Complex Care Group to all referrals made
- Participate in the Health Complex Care Group as a core member, providing both ASC and CYPFS representation in each case.

HTFT will have regard to the SEND code of practice, in particular the requirements of:

- S8.54 to support the transition to adulthood,
- S8.55 the duty to co-operate
- S8.56 the additional requirements for people transitioning from CYPFS mental health services.

Together, these create duties to gain a good understanding of the young person's individual needs, including their learning difficulties or disabilities, to co-ordinate health care around those needs and to ensure continuity and the best outcomes for the young person.

When people are transitioning into adult mental health services, there is an additional duty to refer to The Mental Health Action Plan, Closing the Gap: Priorities for essential change in mental health, which identifies transition from CAMHS to adult services as a priority for action.

The SEND code of practice summarises these duties. This means working with the young person to develop a transition plan that identifies who will take the lead in coordinating care and referrals to other services.
Following the SEND code of practice HTFT will meet their responsibility delegated to them under the terms of the Section 75 Agreement to discharge the duty placed upon the CCG by S3.65:

As health service commissioners, CCGs have a duty under Section 3 of the NHS Act 2006 to arrange health care provision for the people for whom they are responsible to meet their reasonable health needs. Where there is provision which has been agreed in the health element of an EHC plan, health commissioners must put arrangements in place to secure that provision.

13. The Continuing Healthcare Team (CHC)

If the young person is in receipt of Continuing Care, arrangements for the assessment for, and transition to NHS Continuing Healthcare will be made.

Continuing Health Care funding is provided to people with a long term, primary health need. It is not available to people who have a short term, acute health problem or to people whose needs relate mainly to social care

As healthcare is free at the point of delivery, eligibility means that people able to access this funding will not be required to make a contribution to the cost of their care and support

If someone is in the closing stages of life with a rapidly deteriorating condition, a clinician can complete a fast track referral which means that funding can be given immediately with no further assessment taking place. If this is not the case, then a multidisciplinary team (MDT) of people from across health and social care will meet with the person and their family to carry out an assessment

13.1 The Continuing Healthcare Team will:

Complete an assessment after any treatment or therapy for the condition has been completed. The assessment will be recorded on the decision support tool (DST).

A primary health need will be established by looking at someone's needs across 12 domains:

- Behaviour,
- Cognition,
- Psychological and Emotional Needs,
- Communication,
- Mobility,
- Nutrition,
- Continence,
- Skin,
- Breathing,
- Medication,
- Altered states of consciousness and
- Other significant needs.

If someone has a severe level of need in two or more of these domains, then that is enough to establish eligibility. If they do not, then the MDT will look at the nature of someone's needs, the intensity, complexity and unpredictability of these needs.

The MDT will make a recommendation to a panel of people from Continuing Health Care, the CCG and the local authority. The panel will look at how the assessment was carried out, whether the level of need has been accurately identified within the domain findings and whether the recommendation reflects the level of need that has been identified. If eligibility is not established and the person or their representative disagrees with this, they can lodge an appeal within 6 months and the evidence will be reconsidered. If eligibility is established, reviews will be carried out after three months and then annually to make sure the person's needs have not changed. If someone does not have a primary health need, but still has health related needs, other forms of NHS support or funding may be available

14. Integrated Commissioning

The Integrated (Hull Clinical Commissioning Group (CCG) and Hull City Council (HCC)) Commissioning Service is responsible for market shaping and the commissioning of care and support providers. There is recognition of the importance

of communicating to the market the potential requirement for specialist services for children in transition to adult services

The Integrated Commissioning Service commits to using the transitions list to inform providers of the likely need for care and support services in the future. This will require integrated working with public health, CCG and wider health and social care colleagues to understand the demographic requirements within the City. This medium to long term planning will enable sufficient, high quality providers to enter the market in the City

15. Shared Lives

Shared Lives can be a constant and consistent base for young people at a challenging time, with Shared Lives carers providing consistent, person-centred support to young people while they navigate these many changes.

Ofsted and the Care Quality Commission (CQC) have an agreement around Shared Lives that CQC will monitor the arrangements for people aged 16 and upwards in Shared Lives schemes in line with the Fundamental Standards and Key Lines of Enquiry. There are additional requirements upon carers to understand and be able to apply the different legal frameworks for children and for adults, and upon scheme managers to ensure different agencies are aware of the continuing need to discharge their duties to the person during transition regardless of how their support needs are being met.

Many young people in transition who move in to Shared Lives have previously been fostered. Although the principles of living with an individual or family in their home is the same, there are some important differences between Fostering and Shared Lives. These include the following:

15.1 Accommodation:

- Shared Lives carers are expected to provide accommodation which the person using Shared Lives will rent from the carer, possibly via Housing Benefit
- The person will have their own key to the home.
- As the person is renting the room they may wish for their room to be more personalised to their tastes
- People living in Shared Lives cannot share their room with another person unless they are a couple and wish to do so

15.2 Finance:

- The person will pay their rent, utilities and food directly to the carer from their benefits
- The scheme will pay the carer a fee for the care and support they offer to the person. Because of the different payments made for accommodation, utilities and food, this payment will not be the same as the fee paid for a foster placement.
- The person will receive their benefits directly in to their bank account. Any support they need to manage these will be assessed by the ASC worker, and this could include Corporate Appointeeship. This includes any Personal Independence Payment (PIP)
- The person will be responsible for buying any personal possessions such as clothing, electronic equipment and holidays from their money.

- The overall income for the placement may be different. However as the person will hold their money the Shared Lives carer will receive less but will not be responsible for the client's personal expenditure
- Shared Lives carers are classed as self-employed and are entitled to tax concessions. This is currently £250 p/w per person using Shared Lives plus £10,000 totalling £23,000. This may change so seek advice from your Shared Lives scheme.
- Shared Lives carers are not entitled to Carers Allowance for the person staying with them and are unlikely to be entitled to any means tested state benefits.
- Shared Lives carers are required to keep records of finances, medication and key incidents and present them when requested.

15.3 Foster Carers transitioning to be Shared Lives Carers:

Young people in transition experience a major change in moving from children's to adult services. It may provide a smoother transition for young people with support needs to remain with their foster carers and live as an adult in the household. This requires foster carers to become Shared Lives carers.

The foster child needs to be assessed by an adult care manager as having eligible care and support needs to be funded as an adult, and that it is their wish to remain living with the foster carers or, if they lack the mental capacity to decide, that it is in their best interest to do so.

If the young person does not meet the eligibility criteria for Adult Social Care services, then a Staying Put arrangement maybe offered.

Foster Carers need to apply to be assessed and approved as Shared Lives carers by a registered Shared Lives scheme. This will involve attending meetings and undertaking training.
Although Foster Care and Shared Lives have similarities, the aim of the Shared Lives is to support young people to live as adults and highlights the rights and needs of young people in becoming more independent. In some instances, this may involve young people preparing to leave the home. The Shared Lives scheme will support foster carers to transition to Shared Lives by assessing their capacity and abilities to support the young person to have a life outside of the family home, connect the young person with their community and develop and grow as a young adult.

16. Appendices

Appendix 1: Key concepts and principles used in developing the protocol

Mental Capacity assessments and Best Interest decision making

The Mental Capacity Act 2005 (MCA) was enacted in order to empower people with a mental impairment to make decisions for themselves wherever possible and to protect those who lack capacity by providing a flexible framework that places people at the heart of decision making. It ensures that people participate as much as possible in decisions made on their behalf, and that those decisions are made in their best interest.

The MCA applies in England and Wales and has five key principles:

1. Every adult has the right to make his or her own decisions and must be presumed to have the capacity to do so unless it can be proven otherwise;
2. A person must be given all practicable help to support their decision making;
3. A person should not be regarded as lacking capacity if they make an unwise decision;
4. Any decision made on behalf of a person who does lack capacity, or any actions taken in respect of them must be demonstrably in their best interest;
5. Any decision made or action taken on behalf of a person who lacks capacity must be the least restrictive of their basic rights and freedoms.

When assessing the capacity of someone, it is vital to remember that the assessment is time and decision specific. There can be no generalised judgement that a person simply lacks capacity. If all help has been given and the person still appears to lack the capacity to make the decision, an assessment of their capacity to make that particular decision should be made.
The Code of Practice which accompanies the MCA outlines a two stage test which is:

A. Does the person have an impairment of the mind or brain, or is there some disturbance affecting the way their mind works?
B. This may be temporary or permanent; if so, does that impairment or disturbance mean the person is unable to make the decision in question at the time it needs to be made?

The assessment consists of four questions, which are:

- Does the person understand the relevant information?
- It is not necessary for the person to understand every element of what is being explained to them. What is important is that they can understand the salient points; the information relevant to the decision. The level of understanding must not be set unreasonably high.

- Can the person retain the relevant information?
- The key issue is whether the person can retain enough information for a sufficient time to make the decision. The Act specifies at s3(3) that 'the fact that a person is able to retain the information relevant to a decision for a short period only does not prevent him from being regarded as able to make the decision.'

Can the person use or weigh the information relevant to this decision?
This part of the test has been described as 'the capacity actually to engage in the decision making process itself and to be able to see the various aspects of the argument and to relate the one to the other.' It is particularly important not to equate an unwise decision with the inability to make one. The person may not agree with the advice of professionals but that does not mean they cannot make the decision.

- Can the person communicate their decision in any way?

If the answer to any of these questions is no and there is clear evidence to support, then the presumption that the person has capacity can be rebutted and they can be found to lack mental capacity in relation to that particular decision. A decision must then be made in their best interest.

Best Interest decision making

Someone can only make a decision on behalf of someone else if that person lacks

the mental capacity to make that particular decision for themselves. The worker cannot make a decision on behalf of someone who has capacity just because s/he disagrees with the decision they have made, or feels it to be a risky decision. A formal assessment of capacity must be made

When making a best interest decision, the worker must consider the person's current and future interests, weigh them up and decide on balance, which is the best course of action for that person. If the person does not have capacity, the assessor must consider whether they are likely to regain it in the near future either due to recovery from illness or because they have fluctuating capacity. If they are likely to regain capacity, the decision should be put off until then if possible, so that they can make the decision themselves.

If the person is unlikely to regain capacity then decisions must be made on their behalf. These must always be the least restrictive option and be in their best interest.

In order to work out what this is, the worker making the best interest decision (which may be a different person to the assessor of capacity) must:

- Find out if there is any advance statement made by the person when they had capacity which explains what they want to do;
- Consider all relevant circumstances;
- Encourage the person to contribute to the decision making process as far as they are able;
- Consider the person's past and present wishes and feelings;
- Consider their religious, moral, cultural or political beliefs and values;
- Take into account the views of their carers, family, friends and anyone named by them as someone to be consulted, but be aware that unless one of them holds a Lasting Power of Attorney to make welfare decisions, their wishes are not paramount. They must be taken account of, but not necessarily followed;
- Be able to show the proposed course of action is the least restrictive alternative;

If someone holds a valid Lasting Power of Attorney which has been registered and activated by the Court of Protection they can make decisions on the person's behalf provided that

- They can show that the decision they make is in what they reasonably believe to be the person's best interest; and
- It is within the scope of the LPA. Someone who holds an LPA for finance and property cannot make decisions about a person's health and welfare and vice versa.

A person without capacity can contribute to the decision making process verbally, through their reactions or through their behaviour. These must be taken into account when reaching a Best Interest decision, although they do not have to be followed if there is a strong reason to override the person's expressed preferences. Examples of good reasons would be that the person's expressed preference would put them or others at a significant degree of risk which they do not understand or that their current expressed preferences seem to go against the values they held when they had capacity.
Anyone making a Best Interest decision for someone else must guard against making the decision which they would make if they were in that person's situation.

Deprivation of Liberty safeguards

The Mental Capacity Act provides that no one who lacks capacity to consent should be deprived of their liberty without proper authorisation. The Supreme Court has established that someone is deprived of liberty if they are under continuous supervision and control and they are not free to leave. Many residential placements and some community provisions meet these criteria and If the person is aged 16 or over, this must be authorised either by an application to the local authority or, for community settings by an application to the Court of Protection. The person who is deprived of liberty has a right of appeal to the Court of Protection.

Advocacy

An understanding that people should be able to make their own decisions and control their lives; however there may be times when young people and their representatives need some support and the use of advocates needs to be considered.

Coproduction

Co-production means professionals and citizens sharing power to design, plan and deliver support together. It's about recognising that everyone has an important contribution to make to improve quality of life for people and communities.

The need to develop transition arrangements alongside families and young people has never been more necessary. Austerity means the demands that are being placed on family carers as well as the statutory sector are greater than ever. Supporting people in a caring role, helping young people develop their independence and fulfilling our statutory duties means we all have to work together. Imposing systems and processes into this complex environment will neither be affordable or effective.

Co-ordinated strategic approach

All people agencies involved in the transitions process have been consulted in the preparation of this protocol, which also takes account of, and builds upon, the SEND Code of Practice, as well as the relevant legislation detailed above. The strategic collaboration shown through the Strategic Transitions Group will continue, as the group will oversee delivery of the agreed protocol.

Choice and control for young people and families

People achieve greater health and wellbeing when they are more involved in the decisions and process that affect them. Designing care and support around their needs and circumstances of young people and families prevents crises in people's lives that lead to unplanned hospital and institutional care, and reduces the overall use of formal services.

Focus on independence and responsibility

In this protocol we prioritise the notions of independence and responsibility, however, what we mean by independence and how we use the term responsibility needs to be carefully stated. This is because the terms can be used in a variety of ways by different people. In this protocol, when we use the terms independence and responsibility we mean these things:

- Encouraging a young person to do as much as they can for themselves
- Keeping or improving physical and cognitive function so that a young person

can fulfil the tasks of independent living

- Improving or maintaining social connections, and individuals making decisions about their own care as far as possible
- A young person learning to take responsibility for themselves and their actions
- An organisation delivering actions that meet their legal duties and obligations

Person centred planning

Person centred planning is a process of life planning for individuals, based around the principles of inclusion and the social model of disability. Person centred planning tools are alive and active, always ensuring the focus person is central and in control. They are flexible, setting no limits to the person's wants, needs and dreams for their life.

In person centred planning, the process, as well as the product, is owned and controlled by the person (and sometimes their closest family and friends). The review should create a comprehensive portrait of who the person is and what they want to do with their life and brings together all of the people who are important to the person including family, friends, neighbours, support workers and other professionals involved in their lives. The resulting plan of support is totally individual.

Person centred planning replaces more traditional styles of assessment and planning which are based on a medical model approach to people's needs.

Clear commitments that can be monitored

There is an expectation that the commitments made by organisations and agencies in this protocol are commitments that will be monitored. Furthermore, the expectation is that that the organisations and agencies making commitments in this protocol will prioritise any necessary actions to comply with their commitments.

Sector wide pathways

The purpose of the protocol is to being activities and practice together across young people's journeys through the health and social care system, and to support families to understand that journey and what it means to them. To work across all partners in more effective and efficient ways, wherever an individual's pathway begins and ends.

Sector wide commitment

Whilst it is the Local Authority that is taking the lead, the partners to this protocol understand and accept that a successful transition between childhood and adulthood requires high level leadership commitment from all partners in the Health and Social Care sector. In recognition of this, signatories to the protocol accept the need for joint action and participation to make transitions work for every young person in Hull