

national transition support team

working together to improve transition
for disabled young people

Case Study: Essex County Council

Introduction

Working together to support one young person to remain in family based care into their adult life.

Overview

This case study looks at the complexities of supporting a young person through transition who lives with foster carers out of the local area.

It also considers how joined up planning enabled one young person to continue to reside with his foster carers and build an adult life in familiar surroundings.

Main transferable learning points

- Having shared computer data base systems can significantly support transition planning both operationally and strategically
- It is essential that workers in Adult services have a good grasp of services and support available in Children's services and vice versa
- Having a joint approach to planning from 14 will support a more positive transition

Introduction

Essex County Council's Social Services help young people who are at risk of abuse, with disabilities or special needs, care leavers, young people who are a risk to themselves or to others; and young people who cannot live at home with their families. Essex County Council have a duty to provide services that safeguard and promote the welfare of young people in need, including fostering, adoption and residential children's homes.

This case study will be focusing on the work by the Learning Disabilities and Physical Impairment Team within the Adult, Health and Community Wellbeing Directorate and in particular the work carried out in terms of transition from childhood to adulthood for young people from 17-20 years old. Most of these young people have complex needs that require a high level of support.

One particularly young person gives a good example of the work that we have been doing to support a positive transition to adult life. We have called this young person Ben.

Introducing Ben

Ben is a young man in transition from Children with Disabilities Team (CWD) to Adult Social Care. Ben is a complex young man with a range of needs. He requires support around his health and learning disability and can be known

to display behavior that challenges.

He was living out of county with an Essex County Council foster carer. Prior to living out of county, Ben lived in a therapeutic residential placement costing approximately £2000 per week; however the placement broke down as the provider proved unable to meet Ben's needs. It was at this point Ben moved to his out of county placement to live with his foster carer.

As Ben passed his seventeenth birthday we began to prepare for the transition from children's to adult social services. His opinion was sought and he clearly stated that he wanted to remain with his current foster carer as an adult. The foster carer also felt strongly that this would be in Ben's best interest and that they could continue to help Ben. It was clear to Essex County Council that this seemed the best plan for Ben as he was happy with his carer and did not want to return to Essex.

To enable Ben to remain with his foster carer Essex County Council's Adult Social Services team arranged for the foster carer to become a registered shared lives carer. Shared lives carers offer supported living to people in the carer's own home. The introduction of a personal budget could also allow for flexible use of ECC funds that could lead to better outcomes and continuity for Ben.

The plan also gave Ben the opportunity to have greater control over his own care.

Background

The problem being addressed.

This case highlighted two common problems experienced at the point of Transition for looked after people with complex needs:

'Ordinary Residence'

Working across counties caused a number of problems. The 'host' local authority was at first reluctant to discuss Ben's case and resources; therefore there was an initial lack of

cooperation/communication from the authority in whose area Ben was living. The out of county local authority was also concerned that if their adult placement team became involved then Essex would absolve their responsibility, using this receipt of service to define the Young Person as meeting the condition of 'ordinary residence' in the host area, and this would set precedence for future out of county cases.

Lack of Integrated Systems between Children and Adult services:

Another issue related to Essex County Council computer systems. The current computer system operates two separate programmes for children's and adult services. The programmes do not work together and made the access and collation of information difficult. This could have had a detrimental impact on this young person's transition.

What drove the work? What were the drivers for change?

Young People with such complex and high levels of need as Ben has challenged Transition Services to overcome significant barriers that often still exist between Children and Adult services.

Whilst this group is undeniably eligible for an adult service, prior to the advent of personalisation and the personal budget, it would often prove difficult for organisations to continue an existing successful placement into adulthood. This challenge can be compounded when the placement is 'out of county'.

In this instance both the service user and the carer's expressed wishes that the placement continue into adulthood was a significant driver.

This, combined with Essex County Councils commitment to self directed support meant that we had an opportunity to show how we could effectively overcome these barriers to support a positive pre existing placement into adulthood.

The main driver for change was to continue to

improve the transition of young people from children's to adult social services. The main focus was a person centered approach, which put the young person at the heart of everything we do and increases independence, choice and control.

The context for the work covered by this case study.

In order to complete a transition case the social services team complete several assessments including:

- Core Assessments
- Looked After Child Review
- Disabled Person Assessment
- Community Care Assessment
- Mental Capacity Assessment
- Support Plan and Support Plan summary
- Housing benefit assessment
- Financial Assessment
- Separate care plans and risk assessments in conjunction with 'shared lives' scheme providers.

The Adult Social Services team also worked very closely with the following:

- Children with Disabilities team including carrying out joint assessments (Community Care and Mental Capacity) and support plans.
- The shared lives placement provider for Essex who worked with ECC to register Ben's foster carer as a shared lives carer.
- The out of county local authority to agree roles and responsibilities and next steps in regards to Ben's support as an adult.

- The Adult Social Services team also carried out joint visits to the young person and foster carer as there were high levels of anxiety during this time. The visits were designed to support and involve Ben and his carer and reduce some of the anxiety.
- Foster carer to ensure roles and responsibilities were clear as a shared lives carer as apposed to prior foster carer status.
- Relevant education provider to ensure they were aware of transitions and possible impact of change in social worker on Ben's mental and emotional wellbeing due to separation and loss issues.

Aims and Objectives

Purpose

The overall purpose of the Adult Social Services team was to improve the transition of a very vulnerable young person, ensure continuity of care and development, enhance independence, choice and control for the service user and demonstrate that this could be achieved within a complex context, thereby building on improved transition practices by:

- Early intervention which ensures a young person and their family/carer(s) can plan for the future and adjust to changes earlier on.
- Develop an integrated approach to an early intervention in order to assist person centered assessments and support plans
- Joined up assessments and support plans
- Earlier intervention to ensure all support needs addressed including social care, health, finances (including management via Mental

Capacity Act and ensuring all eligible benefits are in place/applied for)

- Coherent and confident early advice and information
- Flexible funding via personal budgets which also decreases dependency on social care by taking control of their own life/support.
- More active lives and greater community involvement through person centered support plans, building on resources known to the young person.

What benefits was the organisation trying to realise?

Overall the placement offered Ben stability, continuity and safety and enabled him to continue to develop his social networks and capacity for independence. All of these factors are fundamental in maintaining Ben's overall wellbeing.

Essex County Council was also mindful of costs and it was clear that Ben's current placement was not only beneficial for Ben's wellbeing but was also cost effective. The placement cost £650 per week; where as the alternative residential care would cost an estimated £2000 - £3000 per week.

Long and short-term goals of the project

The success of Ben's placement was already clear; he had resided with his carer very successful for several years. Therefore the focus of the work was about maintaining the placement which offered stability and consistency to Ben and most importantly it was what both Ben and his carer wanted.

Therefore it was agreed that the placement would not be transitional but rather a long term plan thus securing that continued stability for this young person that took into consideration his bespoke requirements, arising from his physical care needs, his mental health needs, his childhood trauma, emotional needs (as outlined above) and loss and separation difficulties.

How the work was planned

Due to Ben's communication limitations the Adult Social Services team were unable to communicate with him via telephone, therefore regular meetings were set up to discuss transition planning. The Transition planning involved a number of professionals including the foster carer, CWD social worker, school and the shared lives scheme provider. These meetings enabled a person centered approach to the transition process and ensured Ben's hopes and dreams were at the heart of the decision making.

Project milestones

The key milestones for most transition cases are as follows:

- 28 days to complete a community care assessment
- Six months prior to a young person's 18th birthday their social worker will present the results of the community care assessment at panel, the objective of this is to establish the need for continued support.
- Three months prior to a young person's 18th birthday funding needs to be confirmed and support plan developed.

However in this case the assessment of need was confirmed eight months prior to the young persons 18th birthday and the support plan was validated 5 months before his 18th birthday. Securing funding and support early put everyone's mind at ease and enabled the professionals to focus on other areas including Housing benefit. Applying for Housing Benefit was completed, as it can only be, one month prior to a young person's 18th birthday. In Ben's case there were significant issues with his application as they required archived court orders in order to evidence leaving care.

Key people

The key people involved in this case included:

The Children with Disabilities team and the Adults with Disabilities team – these teams provided the front line service and ensured all the day to day/ground work was completed on time to ensure a smooth transition in an integrated manner supported by the Transition Pathway Service.

The Service Placement Team which was involved in liaising with the shared lives placement provider including sharing of contract and service user details.

The Shared Lives Provider who completed assessments and care plans with Ben, his carer and Ben's Social Worker.

The Adult Social Services Operational Service Manager was involved in the funding process and was required to audit and approve costs. The funding request was above the standard banding but considering Ben's complex needs and the fact the alternative care would have cost between £2000 - £3000 per week, funding was approved.

How the project was financed;

The management of personal budgets were discussed and offered to Ben and his carer, however due to the role and contract of the 'shared lives' scheme this element of the budget is being managed by Essex County Council and currently is being paid directly to the shared lives provider who are able to offer flexibility as they also manage respite and day centre funding. Also using the self directed support (SDS) approach Ben's indicative budget was able to be used with great flexibility, meeting his substantial and critical needs whilst maintaining cost effective support.

Challenges and issues

The Adult Social Services team encountered a number of problems including:

Social workers were aware of the shared lives

scheme but not how it worked and the procedures they needed to follow; therefore they had to investigate and test the programme and establish how it was going to work for Ben.

Essex County Council has two separate computer systems (Oscars/Protocol). These two computer systems made it difficult to carry out joint assessments as they do not link/share information. It therefore becomes a manual and time consuming process for the social worker.

Gaining Housing benefit was very difficult. As a looked after child there was more paper work and initially the housing benefits office wanted a copy of the original care order.

These problems were combined with difficulties with the out of county local authority that was reluctant to discuss the case or possible resources.

• How they were overcome

These issues were overcome through the effective intervention of senior management across departments both in Essex and out of county. Ben's social worker flagged the issues and sought the support of senior managers and by working together they shared knowledge and shared tasks.

Without the benefit of an involved and understanding management, Ben's social worker would have been under greater pressure to seek a less bespoke solution to his adult care.

• What would we do differently next time?

Despite some of the initial problems Ben's transition went smoothly and looking back all concerned are very happy with the outcome and therefore would not change their approach for future out of county cases. We will however build upon the experience and efficiency of engaging all parties in the

organisation in problem resolution. In fact we

feel that the joint working that took place at all levels in the organisation and the provider; 'shared lives' programme are examples of best practice.

Successes

• Specific challenges we overcame.

The biggest challenges are as described above i.e. developing social workers understanding of the shared lives scheme, the ECC computer systems, obtaining housing benefit and difficulties with the out of county local authority and their reluctance to discuss the case.

• What were the biggest contributors to these successes?

Joint working is definitely the biggest contributor to the success of the case. This aided information sharing and shared responsibilities. This also enabled the incoming Adult Social workers to build an excellent relationship with the foster carer which eased the carers concerns.

• Benefits of the project.

The main benefit of the project was that this very vulnerable young person was able to stay with his carer, in an environment that was safe and met all his support needs for the foreseeable future

The Adult Social Care team also developed their understanding of shared lives scheme and further developed their joint working with both internal and external organisations, which in turn will help in future cases.

- Another key achievement was the excellent working relationship between Adult Social Services and CWD including joint assessments (Community Care and Mental Capacity) and support plan, which with joint knowledge and a shared perspective lead to a more person centered, holistic, integrated assessment with in depth paperwork and improved outcomes.

• Feedback from young people and their

families.

Ben does not fully understand the transition process or the above successes/difficulties. What he has experienced, is that he has been listened to, and his requests have been met and he will not lose his family life.

Ben's 'shared lives' carer is happy to be able to continue to care for him as Ben is seen as a member of the family. Ben's carer was anxious prior to transition that he would be placed in a residential home and is now pleased that a way has been found to make him a permanent member of the family.

Conclusion

• What was achieved?

This young man, with very complex physical and emotional needs, expressed his desire to stay with his foster carer post 18 years and into his adult life. His foster carer also shared this desire and is totally committed to his wellbeing. Therefore as a result of an effective transition programme, which was person centered, Ben was able to stay with his foster carer, who is now known as his 'shared lives' carer.

• Benefits that have already been realised.

The main, and most important benefit that has been realised, is Ben's wellbeing. Overall the placement offers stability, social networks, continuity and safety, all of which are fundamental in maintaining Ben's happiness.

The placement has also had financial benefits for Essex County Council. Instead of £2000 - £3000 per week the placement is costing £650 per week, a saving of nearly £100,000 per year.

• Future potential benefits

The successful joint working across services has enabled the team to develop effective working relationships for future cases and helped overcome the information issues raised due to the council's computer systems not linking up. The case has also developed the

teams understanding of the Shared Lives Scheme, which can be rolled out to other similar cases.

- **Lessons learned (particularly those relevant to a wider audience)**

Early integrated joint working is key to the success of effective transition. By working with services both internally and external the Adult Social Care workers were able to share knowledge, reduce stress levels and offer Ben and his foster carer greater support and guidance. The joint working also led to joint assessments which are less oppressive and less time consuming for the families and social workers, plus they proved to be very comprehensive and detailed in comparison to separate assessments.

Early joint working also enables the families to receive information throughout the transition process so that they understand what to expect whilst alleviating their worries about future support.

All of this was made possible by person centered planning and ensuring the hopes and dreams of Ben were at the heart of everything. This person centered approach led to a personal budget and delivering a service that was right for Ben i.e. shared lives carer.

- **Future plans**

The Adult Social Services team intends to continue to develop their working relationship that they have established as a result of this case study, both with the CWD team and shared lives scheme.

The Adult Social Services team will also continue to investigate making better use of the shared lives scheme for service users that would benefit from such a programme.

The team will also continue to look at alternative options for service delivery and continue to develop and improve the transition process for young people across the county.

How to...?

The key principle to transition is person centred planning, this case study shows how by listening to the needs of the service user and putting them at the heart of everything we do, you can help a young person achieve their hopes and dreams. The person centred planning also lead to a solution which was not only beneficial to the service user but also to the carer who had the commitment, skills, compassion and desire to care for Ben. The benefits for Essex County Council included a saving of nearly £100,000 due to Adult Social services using a shared lives carer rather than a residential home.

The barriers of computer systems that operate two separate programmes for children's and adult services, making information collation difficult, was over come through effective joint working by the social workers in CWD and adult social services, therefore building relationships across services which will no doubt be beneficial in future cases.

A top tip when dealing with transition process is early integrated intervention, especially for more complex cases. Early intervention will aid the person centred assessments and support plans and ensure a young person and their family can plan for the future and adjust to changes earlier on. Planning ahead also helps the professionals ensure everything is in place including social care, health care and finances (management via

Mental Capacity Act and ensuring all eligible benefits are in place or applied for). Another top tip is joint assessments; this process is far less time consuming and less stressful for everyone involved.

This case study also demonstrates Social workers willingness to try something new via the shared lives scheme. By social workers taking the initiative, testing and challenging a new service provider they are opening up new opportunities for their service users and improving the transition process.

Finally flexible funding via personal budgets decreases dependency on social care by enabling service users to take control of their

own life and support needs. In turn this also offers a more flexible approach to social care services and in this case saves the local authority a large amount of money which in turn can be used on alternative services.

Organisations and websites/useful resources

- Essex County Council:
www.essex.gov.uk
- Person Centered Planning:
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_115175
- *Mental Capacity Act*:
www.legislation.gov.uk/ukpga/2005/9/contents
- *Safeguarding*:
www.dcsf.gov.uk/everychildmatters/safeguardingandsocialcare/safeguardingchildren/safeguarding
- Community Care Assessment:
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_4088476
- Shared Lives Scheme:
www.reading.gov.uk/healthandsocialcare/fosteringadoptionandothercarerschemes/sharedlives
- Essex County Council Putting Essex People First Information Gateway
www.essexcc.gov.uk/vip9/portal

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National Transition Support Team (NTST)

NTST is working alongside the National Strategies and the Child Health and Maternity Partnership to coordinate the delivery of the Transition Support Programme.

NTST is based at the Council for Disabled Children (CDC), the umbrella body for the disabled children's sector in England. CDC is hosted by NCB. www.ncb.org.uk/cdc

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