



# SITE PROFILES AND RESOURCES

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PROFILES, PORTRAITS AND TOOLS FROM NAMED SOCIAL WORKERS WHO TOOK PART IN THE NAMED SOCIAL WORKER PROGRAMME.

JULY 2018

This set of resources complements [‘Putting people at the heart of social work. Lessons from the Named Social Worker Programme’](#). It shares the site profiles as well as some of the tools, stories and resources that have been created throughout the programme.

You can access the suite of products created by the programme team to showcase impact by clicking on the hyperlinks below:

- [A Service User’s journey](#) - A story of impact: experience of a service user supported by a Named Social Worker and their family
- [Big Plans](#) - a guide to meaningfully engaging people with learning disabilities in the development of their plan
- [Ten steps to creating your own cost benefit analysis](#) - a tool to help you quantify the monetary impact of new service interventions
- [Evaluation Summary Report](#) and [suite of evaluation materials](#) produced by SCIE - a set of documents that analyse the impact and learning from the programme

Scroll on to read short summaries of each site’s approach and helpful documents produced by sites as they have been developing and implementing their Named Social Worker approaches:

- [Named Social Worker Phase 2 site profiles](#)
- [Named social worker profiles](#)
- [Bradford’s reflective supervision template](#)
- [Bradford’s risk enablement panel framework](#)
- [Bradford knowledge and skill statement for advanced practice](#)
- [Halton’s transitions protocol](#)
- [Sheffield’s NSW practice framework](#)
- [Disability and society journal article from bradford - Named social workers – better social work for learning disabled people?](#)

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# Site profiles

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# Bradford



*Our Vision is...* citizens and social workers being side by side, with citizens having the power to say how they want their lives to be led. A human rights-based approach that supports people to live independently in communities.

## In phase 2 of the Named Social Worker programme we aim to:

- Have five named social workers starting a process of culture change that makes citizens' human rights the focus of social work
- Promote independent living and minimise the use of settings that deprive a person of his or her liberty
- Work alongside citizens every step of the way
- Develop a competency framework for advanced social work practitioners

# Sheffield

*Our Vision is...* to develop a professional and meaningful relationship between named social workers and individuals and their families that goes beyond support at crisis point, is proactive, tailored to clients' needs and circumstances and allows for flexibility.

*3 key responsibilities of the NSW:*

- Creating meaningful, professional and person-centered relationships with individuals and their families
- Ensuring a multidisciplinary approach and liaising with other professionals to enable it
- Taking accountability and responsibility for professional decisions whilst advocating for the individual

## **In phase 2 of the Named Social Worker programme we aim to:**

- Spread the Named Social Worker approach to a wider team
- Continue to develop group supervision, channels for named social workers to share knowledge and resources to support named social worker practice
- Improve multi-disciplinary team working with colleagues in health
- Focus on creating more and better opportunities for users and carers to shape services
- Develop a better understanding of the impact and sustainability of the model

# Hertfordshire



*Our vision for the named social worker approach is that it...*

- Situates named social workers as a lynchpin, connector between the individual and other professionals
- Uses a shared collaborative plan (not duplicated in each profession) to create consensus between services
- Makes room for creativity in finding person-centred asset-based solutions
- Is about being open to input and challenge from professionals, individuals and families, it actively seeks feedback and uses it to influence decisions and experience

**In phase 2 of the Named Social Worker programme we aim to...**

- Spread the NSW approach beyond phase 1 practitioners and grow the NSW culture across the service
- Co-design the NSW service offer and experience with service users, carers and frontline staff
- Work more closely in partnership with colleagues in health for more integrated delivery
- Codify the NSW approach in a 'scrapbook' of practice and develop a deeper understanding of its impact and sustainability

# Shropshire



*Our Vision is... to develop a more transparent and accessible transition process in Shropshire that ensures that young people and their families:*

- Have consistent and trusting relationships with their social worker and other service professionals at the point of transition
- Have a clearer understanding of the process of transition and who is involved
- Get transition information earlier and trust the system is going to work
- Are involved in conversations to shape a tailored transition plan so that their needs and aspirations are understood and met

## In phase 2 of the Named Social Worker programme we aim to...

- Develop confidence and competence of social workers
- Develop and prototype a new assessment process for young people that meaningfully involves them as active contributors
- Create training materials and resources that can be used to scale up this new process to all social workers working with young people

# Halton



*Our Vision is...* to develop a new transition service that gives young people, from the age of 14, the best chance of a positive journey into adulthood. The named social worker will build long term relationships with these young people using creative and person-centered approaches to help them map their goals and support them to achieve them.

## In phase 2 of the Named Social Worker programme we aim to:

- Involve young people and families to understand what works already (and what doesn't) in order to develop a new approach to working with the young people who are often seen as most challenging and who often end up in out of area residential placements
- Work with young people and those that support them to develop plans that are true to the strengths and needs of individuals and that help them to thrive within their communities
- Support social workers to reflect together on their practice and to develop a better understanding of the skills and behaviours that enable relational working
- Build on a strong foundation of integrated health and social care services in order to ensure that future planning is seamless



# Liverpool



*Our Vision is...* to develop a new 'transition journey' from children to adult services, building on their strengths and aspirations, promoting their independence, wellbeing and choice. *The principle of the Named Social Worker embodies the foundations of best social work practice. Acting as a key 'connector' across multiple agencies and systems, named social workers will build a meaningful assessment to facilitate an effective transition journey to adult life.*

In phase 2 of the Named Social Worker programme we aim to:

- Ensure that the learning and best practice from phase 1 is embedded in the wider neighbourhood teams
- Extend the learning outcomes from phase 1, to work with young people with complex needs that are transitioning to adult services
- Work in collaboration with young people, parents/carers, social workers, other professional partner agencies/services to develop an effective assessment tool that is co-produced, designed to facilitate a positive journey to adult services and adult life

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# Named social worker profiles

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## Femi - Hertfordshire

### **What made you want to be a social worker?**

I was previously a teacher and I had seen and admired the work of SEN staff. I wanted to work in a slightly different way with people and so I decided to retrain as a social worker.

I have always mainly worked in learning disability teams. I trained in an NHS assessment and treatment unit - a hospital setting where people were detained. This helped to build my experience in dual diagnosis (learning disability and mental health issues) and severe cases. It was a difficult but very rich experience.

I also spent time when training within a supported living environment with people with mild learning disabilities as well as work out in the community.

These experiences combined have given me a rounded experience of both ends of the learning disability spectrum.

### **What is your favourite part of the job?**

As a social worker, you're there solely to support someone and ensure their voice is heard and I get a lot of fulfillment from this. I might be the only person who they talk to and ask for help.

I enjoy working to empower people I'm working with. For me seeing the people I've worked with in hospital and then out in the community gives me a boost of good feeling. I remember one woman, who I had been working with for a while, when she

came out of hospital and was settling in the community, said "thank you for not giving up on me". I think that says it all really.

### **What are some of the hardest aspects?**

There is a real skill in the art of negotiating with other professionals around what is best, and what risks should and shouldn't be taken to make that person's life better. There are lots of very important conversations to be had, and you need to be able to stand up for that person's best interests. You need to know when to compromise, and when to hold on to what you think.

### **What do you think you need to be a great social worker?**

I think the most important social work values are: empathising with people, having excellent communication skills with all types of people (professionals, families and individuals), and good organisation.

These allow you to make sure the people you're working with are empowered, and that their voice is heard.

## Beth, Shropshire

### **What made you want to be a social worker?**

I'd never had contact or knew very much about social work before, but when I finished my undergraduate degree I took a year out and spent much of it working with homeless people. Doing this I realised that that's what I wanted to do: I wanted to help adults, and social work seemed like the way forward.

### **What is your favourite part of the job?**

Working as a social worker, I've always found people interesting and the job has never been boring! I really like having a challenge where you can see that what you've done has made something better for someone. You can see your achievements, even when it takes time to get there.

Since I qualified in 2011, I have always worked under austerity measures and working in 3 different local authorities in this time, I've seen how different teams cope and adapt to this. The reason I wanted to work on the Named Social Worker Pilot was because it demonstrates the type of social work I'd like to be doing all of the time: working alongside people, getting to know them and doing what's best for them, but in normality, there isn't always the luxury of the space and time to do it.

### **What are some of the hardest aspects?**

It's particularly difficult to work with people who are non-verbal, and I'm learning lots about this. We are doing some Makaton training, and working with the co-production

team from the Pilot to learn about and try new and creative methods of communication.

Working in transitions, this means that I can spend more time with young people themselves to find out what they want. I'm trying to not just talk to the parents, but engage with the young person as much as possible. Parents want the best for their children, but sometimes the parents' and the child's versions don't match. Ultimately it's about striving to do what the young person wants, and what's best for them.

### **What do you think you need to be a great social worker?**

***Be a good listener*** - it's something that I'm learning to do: listening, really listening. Not just to what people *are* saying, but also to what they aren't.

***Honesty and openness*** - you have to recognise that you're not the expert here, you're learning. You're not necessarily going to get it right all the time, but you have to be open about that with everyone: young people, parents, teachers and other social workers.

## Helena, Sheffield

### **What made you want to be a social worker?**

I'm not from a social work background, in fact I started out doing a chemistry degree. When I graduated, I was taking the caring role for my grandparents and when they passed away I felt that something was missing and chemistry wasn't filling this.

I became a carer (home help) and did some voluntary work to try and figure what I wanted to do and then from that I found out that I liked to care for older people and so I did a masters in social work. My last placement was with the adult mental health team. They offered me a job and I stayed there for 4 years, before moving to work in mental health and dementia.

After that I worked in generic adults teams, but I didn't feel that I was achieving anything for anyone or that was what social work was supposed to be like. It felt very process driven, and was focused around dealing with crisis. So now I work on discharge from mental health units, mainly with learning disability, transforming care cohorts and case management.

Although it might not seem very relevant, my chemistry background does help with problem solving and logical decision making. It helps me think outside the box and make arguments as to why I think a certain solution might be the best one.

### **What is your favourite part of the job?**

I really enjoy long-term case management and really getting to know people.

If you don't know someone, the amount of time you spend solving the small issues is really big, but if you know them you already have a good starting point and it means you can do things quicker and better for them when there is a problem.

### **What are some of the hardest aspects?**

Social work can be very process driven. There might be 4 or 5 different documents to fill in and it feels like a bit of bureaucracy at times, so that does get frustrating.

Currently, funding is also an obvious issue. It puts constraints on the way we work as social workers: sometimes discharges are delayed because of a lack of appropriate placements or care support and this is very hard for everyone. Funding in the community has also suffered so it's difficult to have people feel safe there. It's at a point where we are expecting carers and support workers on minimum wages to do really difficult jobs and this creates a lot of pressures. It means people leave and the person they're working with sadly then loses that relationship.

For me, I work with some out of area placements. This is really difficult, because you are often trying to work to bring them back to the area, and so you have to be very linked in to what is available and who they are working with in both the area they are living in, and the one they're moving to.

**What do you think you need to be a great social worker?**

Good communication skills are essential: listening and communicating is vital. This is how you empathise with people, and it takes time so you have to be patient.

I really like the problem solving aspect of social work, and I think this is important. You need to be able to think outside the box to help someone, because everyone is different, so you always need to work in different ways. This way you can make sure that they are the core reason for doing everything, not because of assessment processes.

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# Bradford's reflective supervision template

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Reflective Supervision Prompt Sheet

	Score (1 = no issue 2 = some issues – minor actions may be needed 3 = important issues)	Evidence to support score	What actions do you need to take
<b>Mental Capacity</b> <ul style="list-style-type: none"> <li>• Enabling</li> <li>• Open honest discussion</li> <li>• Realistic options</li> </ul>			
<b>Human Rights</b> <ul style="list-style-type: none"> <li>• Private and family life – how is this respected</li> <li>• Article 5</li> </ul>			
<b>Decision making/unwise decisions</b> <ul style="list-style-type: none"> <li>• Is the person free to make their own decisions</li> <li>• Are they supported to do so/need to be supported</li> <li>• What are the barriers?</li> </ul>			
<b>Positive Risk Taking</b> <ul style="list-style-type: none"> <li>• Is the person supported to take positive risks?</li> <li>• What are the risks and are they real?</li> <li>• Whose risk is it? (where does the concern come from?)</li> </ul>			
<b>Autonomy</b> <ul style="list-style-type: none"> <li>• What is important to the individual?</li> <li>• How is autonomy reflected in their life</li> </ul>			



Reflective Supervision Prompt Sheet

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<p><b>Rights and Choice</b></p> <ul style="list-style-type: none"> <li>• What support is needed for the individual to exercise their rights?</li> <li>• How are their rights upheld?</li> <li>• Do they need support?</li> <li>• Do they want support?</li> <li>• What choices are available?</li> <li>• What are the parameters of the available choices?</li> </ul>			
<p><b>Power</b></p> <ul style="list-style-type: none"> <li>• Power imbalances</li> <li>• Abuse of power</li> <li>• Other professionals input/views of their role</li> </ul>			
<p><b>Legal Literacy</b></p> <ul style="list-style-type: none"> <li>• Understanding MCA</li> <li>• Understanding Human Rights Act</li> <li>• Understanding Care Act</li> </ul>			

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Bradford's risk  
enablement panel  
framework

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## **RISK ENABLEMENT PANEL FRAMEWORK**

### **PURPOSE OF DOCUMENT**

To establish a framework for positive risk management within Bradford MDC, in partnership with the individual, carers and external organisations.

### **1. INTRODUCTION**

- 1.1. Risk is part of everyday life, inherent in everything that we do and it is often through taking risks that people learn and develop. Fear of supporting disabled and older people to take reasonable risks in their daily lives and focusing on risk as what can potentially go wrong, can limit opportunities for trying something new or different, and in turn limit positive outcomes for individuals.
- 1.2. Decision making in relation to risk is a difficult and complex process. There is no guarantee that even the clearest set of decision-making guidelines will yield simple solutions to complex problems. Even the most thoughtful and reasonable practitioners may disagree about the best course of action. In this respect decisions concerning risk are no different from complex clinical or other social work decisions.
- 1.3. This framework for supporting decisions is useful and helps to guide the practitioners' decisions; however, it does not guarantee clear-cut solutions or consensus. What it does is ensure systematic, thorough analysis and reflection—essential elements of competent practice.
- 1.4. The Risk Enablement Panel will form part of the Positive Risk Assessment and Action Planning process when identified risks are greater than expected in ordinary life and are perceived as unable to be managed in a manner agreed by all concerned.
- 1.5. Positive Risk Taking has been defined as:

*'...weighing up the potential benefits and harms of exercising one choice of action over another. Identifying the potential risks involved, and developing plans and actions that reflect the positive potentials and stated priorities of the client. It involves using available resources and support to achieve the desired outcomes, and to minimise the potential harmful outcomes. It is not negligent ignorance of the potential risks...it is usually a very carefully thought out strategy for managing a specific situation or set of circumstances.'*

*(Steve Morgan, 2004, Positive risk-taking: an idea whose time has come. Health Care Risk Report, 10 (10):18-19.)*

Before accessing the panel therefore, workers should follow usual Positive Risk Assessment and Action Planning processes.

## 2. POLICY & LEGISLATION

- 2.1. Government Policies have responded to people's need for more control over their lives and the ability to make real choices about the support that they require and the way it is delivered.
- 2.2. The Government have produced a White Paper on Social Care, Caring for our Future – **Reforming Care and Support**, HM Government (July 2012). The White Paper is built on the premise that 'people (we) all want to live a full and active life, to live independently and to play a full part in our communities'.
- 2.3. The following key documents are also directed at achieving greater personalisation and dealing with risk:
  - *Think Local Act Personal: New sector-wide partnership agreement for transforming adult social (2011)*
  - *Making it Real: Marking progress towards personalised, community based support (2012)*
  - *Enabling risk, Ensuring Safety: Self-directed support and personal budgets (Social Care Institute for Excellence 2010)*
  - *The Care Act 2014*
  - *The Care Act 2014 Statutory Guidance*
  - *Mental Capacity Act 2005*
  - *CMBC Mental Capacity Act 2005 Policy (Ref: MCA01)*
  - *Safeguarding Adults West and North Yorkshire & York Multi Agency Policy and Procedures 2015*

## 3. LOCAL CONTEXT

- 3.1. In response to the national agenda, Bradford Council has strategic priorities for Social Care which include:
  - i. Support for individuals and communities will focus on building their resilience and independence.
  - ii. Adults will have their rights promoted, for some this will include protecting them from all forms of abuse or discrimination.
  - iii. We will enable people to take appropriate risks and balance this with the duty of care.
- 3.2. As we support people to have the greatest degree of choice and control over their lives whilst ensuring that we follow safeguarding procedures, the appropriate assessment and management of risk inevitably becomes more apparent and important.

## 4. GUIDING PRINCIPLES

- 4.1. *"The governing principle behind good approaches to risk is that people have the right to live their lives to the full as long as that does not stop others from doing the same." (Independence, choice and risk: a guide to best practice in supported decision making – DH, May 2007.)*

- 4.2.** Promoting Self-Directed Support and empowering individuals to have more choice and control over their lives and to manage their own risk is central to achieving better outcomes for people. By taking account of the benefits in terms of independence, well-being and choice, it should be possible for a person to have a support plan which allows them to manage identified risks and to live their lives in a way that makes sense to them.
- 4.3.** The principles underpinning the Mental Capacity Act 2005 that an individual must be assumed to have mental capacity to make certain decisions unless it is established that they do not, is core to the way we work. Every effort will be made to support the individual with decisions. If an individual has the mental capacity to make an informed decision and chooses to live with that level of risk they are entitled to do so. The law will treat that person as having consented to the risk and so there will be no breach of the duty of care by professionals.
- 4.4.** The local authority remains accountable for the proper use of public funds and is entitled to set limits whilst ensuring that the individuals assessed needs are appropriately met and that human rights are upheld.

## **5. RISK ENABLEMENT PANEL**

### **5.1. Aim.**

The aim of the Risk Enablement Panel is to ensure that individuals and staff feel confident in seeking positive solutions while demonstrating that no one individual is left to make difficult decisions alone. When there is a significant or perceived substantial risk, it will provide a clear process for discussion and shared decision making. The process will ensure that the individual is listened to, has a voice and is fully involved in any decision making with regards to their life.

### **5.2. Objectives.**

- To ensure that all processes support Bradford's priorities for Adult Health and Social Care; with a focus on building individual's and communities' resilience and independence.
- To ensure that people have the right to live their lives to the full as long as that does not stop others from doing the same.
- To ensure that a consistent approach is taken when balancing independence and choice against the risk of harm.
- To provide a forum for discussion and decision making when dealing with difficult decisions regarding risks to the local authority, the individual, their carers, providers and staff.
- To provide a framework for staff to feel supported in their decision making and promote a culture of positive risk management.
- To ensure there is a written record of discussions and the decision making process.

### **5.3. When Panel should be used.**

- The worker must show they have firstly considered risk ordinarily as part of the assessment process.
- Where there is no agreement as to how the risk can be managed in a positive way a referral can be made to the Risk Enablement Panel.
- Panel will only be convened where all other attempts to fully discuss the issues of concern and reach a mutually acceptable agreement with the individual and/or their representative have been explored without a successful conclusion.

#### **5.4. Risks that should be considered**

Any type of risk should be considered. This could include the following:

- Risk to the individual
- Risk to paid carers
- Risk to informal carers
- Risk to the public
- Risk to the reputation of the organisation
- Environmental risks
- Financial or budgetary risk
- Risks around the individual employing

#### **5.5. How the referral is made**

A referral to the Risk Enablement Panel can be made by CBMDC staff from any Adults Care and Social Work services by completing the Referral Form and sending to the Risk Panel email address as soon as possible.

#### **5.6. Frequency and location of meetings**

- i. The Risk Enablement Panel will meet on a fortnightly basis at the minimum or as requested.
- ii. The meetings will take place at a time and in a venue which is acceptable and accessible to enable the individual and/or their carers or representatives to fully and meaningfully participate
- iii. Staff attending the Panel will need to complete the REP1 document prior to the meeting.

#### **5.7. Risk Enablement Panel Responsibilities**

##### **a) The Panel will:**

- Provide a forum to support individuals and staff to consider the potential consequences of any decisions based on pertinent legislation and the guiding principles of this Framework, to arrive at an informed conclusion.
- If a decision regarding risk management is reached, agree the specific course of action to be taken following Panel.
- Make decisions about monitoring arrangements and the frequency of reviews required as part of an ongoing risk enablement strategy.

##### **b) The Panel will not:**

- Replace or act in cases where Adult Safeguarding Procedures or Multi-Agency Protection Panel Arrangements (MAPPA) take precedence.
- Replace the decision making process that sits with the worker or their Team Manager/Leader and any cases presented to the Risk Enablement Panel by workers must evidence that they have followed a clear process in arriving at Panel.
- Authorise the amount or replace the usual sign off process for funding the arrangements.

## 5.8. Membership

The Risk Enablement panel will consist of:

### Core Members

- Chairperson: Principal Social Worker
- Safeguarding Adults Lead
- MCA Lead
- Minute taker

Note: Core members may nominate another manager to attend on their behalf when necessary.

### People to be invited

- The individual concerned
- Any family, carer or advocate requested by the individual to represent them
- Any family or carer who the panel consider to be affected directly by the decision being considered.
- Others involved in management of the case (e.g. Operations Managers) may be invited to attend and contribute, but would not be Panel decision makers.

### Worker

- The worker responsible for the case and/or their Team Manager/Leader
- Relevant multi-disciplinary representation or specialist as needed

### Training

- Opportunities for observation (training function)

## 5.9. Quoracy

In order for decisions to be made there should be a Chair, Minute Taker, and at least one other Panel member in attendance.

## 5.10. Prior to the Meeting

The person presenting the case to the Risk Enablement Panel must ensure that all relevant parties are informed of the impending panel discussion. This must be done using a method of communication appropriate in the individual circumstance.

## 5.11. During the Meeting

- i. All attendees will be made aware of the nature of the case and summarise all steps taken so far to resolve the issue.
- ii. Each party, starting with the individual or their representative, will be invited to present their view of the situation along with their suggested resolution.
- iii. An open discussion will then be facilitated by the Chair to explore and understand the issues and for potential consequences of any decision to be identified.
- iv. The individual and/or their representative will be able to describe their preferred outcome, followed by the views of other parties affected by the decision.
- v. Any decision taken will be agreed in line with statutory requirements and the guiding principles of this Framework.
- vi. The consequences of any actions that are not consistent with the decision taken must be clearly communicated at the meeting and recorded fully.
- vii. The review time scales will also be decided within the meeting.
- viii. All discussions and any agreed actions arising from the meeting must be documented in the Panel minutes.

### **5.12. After Panel**

- i. Following the meeting, the Minute Taker will complete the Decision Form to record the decision of the Panel.
- ii. The decision and the right to complain will be communicated to all parties within three working days of the meeting in writing or using an appropriate communication method for the individual. This may mean someone is required to visit to explain the panel's decision in person if this is the only way to ensure the decision is adequately communicated.
- iii. The decision must be documented in the individual's case records by the allocated worker.
- iv. Copies of relevant documents will be distributed to all involved where appropriate.

### **5.13. Monitoring of Risk Enablement Panel**

The core members of the Risk Enablement Panel will be responsible for monitoring and reviewing the effectiveness of the Panel in conjunction with the relevant Heads of Service.

This will help to:

- Assess the number of cases being presented and the appropriateness of the cases
- Identify knowledge and skills gaps within the organisation and training needs in regard to promoting a positive risk culture.
- Assess whether staff feel more supported in the decision making process around risk
- Highlight the need to update processes and procedures

### **5.14. Governance.**

The Risk Enablement Panel reports through the Performance Board and is accountable to the Directorate Management Team (DMT)



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**Bradford knowledge and skill  
statement for advanced practice**

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# Key Knowledge and Skills Statement for Named Social Workers supporting Adults with Learning Disabilities

## Introduction

This Knowledge and Skills Statement (KSS) sets out what a named social worker supporting adults with learning disabilities should know and be able to do to ensure that effective support is provided which upholds the person's human rights, maintaining their dignity and autonomy.

The statement was co-produced by social workers and managers in partnership with self-advocates from Bradford Talking Media.

The statement is informed by the Department of Health's (DH) KSS for practice supervisors in adult social work, as well as the Professional Capabilities Framework (PCF).

This document includes:

- An overview of the role and attributes of a named social worker
- The Knowledge and Skills Statement / KSS

## The Named Social Worker Role and Attributes

The role of a Named Social Worker to support people with learning disabilities was proposed in UK policy since the early 1970s. During 2017 and 2018 the UK Government piloted the role across 9 Local Authorities in England. The pilots built on the current body of knowledge about the role of social work in improving the quality of life of learning disabled people.

The Named Social Worker has been described as:

- A dedicated caseworker

- The main point of contact for people and their families
- Professional voices of challenge across the system
- Someone who could advocate and coordinate care and support in a more coordinated way

A Named Social Worker is a registered social worker whose role includes supporting adults with a learning disability and/or autism. The role includes integrating human rights law into practice by being an expert in mental capacity and the social model of disability. This statement is aimed at those who are actively supporting adults with learning disabilities in social work roles across a range of settings which employ social workers.

Named Social Workers in learning disabilities can be performed by those operating at different levels of the Professional Capabilities Framework (PCF), 'experienced social worker', 'advanced social worker' and 'consultant social worker'. The KSS has been informed by capability statements across the domains of the PCF at these levels.

- **Values and Ethics**

Named Social Workers should understand that people are entitled to choose their place of residence and where and with whom they live on an equal basis with others in keeping with their rights under Article 19 United Nations Convention on the Rights of Persons with Disabilities. They should understand that people are not obliged to live in a particular living arrangement otherwise than in accordance with the Mental Capacity Act 2005 or the Mental Health Act 1983. They should understand that the role of a social worker is to enable people to remain in control, feeling safe and empowered by having a professional who is knowledgeable about their individual needs, and the legal framework for decision making where the person lacks the capacity to make the specific decision about their place of residence and/or need for care and treatment.

Named Social Workers should understand and uphold values and ethics that embody anti-oppressive and anti-discriminatory practice. They should understand equality, in particular

the application of protected characteristics in relation to learning disability. Continuous positive regard is integral to all interactions with individuals and Named Social Workers should seek to re-define negative views and stereotypes, challenging societal norms that disable the people we work with.

- **Rights Based Practice**

Rights based practice should underpin all work undertaken by Named Social Worker's with people with learning disabilities. They should understand that Human Rights are universal, using the CRPD as well as the Human Rights Act to advocate, uphold and embed rights based practice.

Rights based practice extends to notions of citizenship and social justice and Named Social Worker's should understand these concepts in relation to work they undertake, seeking to support individuals to understand and explore their lives and rights as citizens and what this means to them.

Named Social Worker's need to understand and apply the social model of disability to their work, understanding the disabling nature of people's situations and experiences, exploring the impact of these on people's lives and seeking to address these through their work. Strengths based practice should allow Named Social Worker's to focus on the ways in which people can maintain choice and control over their lives, exploring positive, protective factors that can be built upon.

To implement rights based practice, Named Social Workers need to consider and analyse the role of power in relationships, structures and systems, understanding the impact this has on the experience of people with learning disabilities and seeking to re-dress power imbalances in favour of the rights, experience and expertise of the individual.

- **Legal Literacy**

Named Social Worker's must possess a high level of legal literacy and understand its integral role in everyday practice. This should include in-depth knowledge of the MCA, the practical application of the 5 principles and the role of case law in defining and shaping the MCA. An in depth knowledge of the process of Best Interests decisions is integral, upholding and promoting the importance of factors such as happiness and past and present wishes and feelings.

The Human Rights Act should be a fundamental piece of legislation for Named Social Workers, in particular Articles 5 and 8 need to be understood and applied in relation to people's right to independence, privacy, choice, control and least restrictive options.

Named Social Worker's need to understand the role and function of the Court of Protection in practice, being able to identify when legal advice needs to be sought and the Court of Protection engaged.

Named Social Workers should continuously update their legal knowledge, ensuring they are aware of any relevant case law judgements, guides, supporting documents and changing and emerging areas.

They should also commit to informing individuals of their rights within the law, for example, the right to seek legal advice, the right to challenge decisions and access advocacy.

Named Social Workers should actively support the use of easy read guides and work collaboratively with user led organisations in the promotion of legal rights in all areas of life, including subjects such as voting.

- **Risk Enablement**

Named Social Workers should be able to make use of risk enablement processes, to be the space where the person, their family and/or carer, their advocate and other members of the MDT can work collaboratively to agree the least restrictive approach towards meeting care and support needs and enabling risk.

They should actively encourage and be involved with the implementation and continuation of resources such as Risk Enablement Panels, seeking a wider discussion of risk, encompassing a rights based approach.

They should promote and engage with positive risk assessment and positive risk taking which involves a sophisticated understanding and exploration of the notion of risk, seeking to clarify the views of those involved, exploring the ownership of risk and separating out professional anxieties from actual risks. This includes understanding and balancing the need for support and intervention with individual's Human Rights, state interference and social control.

- **Case Based Reasoning**

Named Social Workers should be able to provide clear and concise reasoning that evidences the decisions they have taken, including how the person has been involved, use of legal frameworks to inform decision making, and reasons for any decisions made in a person's best interest. Named Social Workers should also understand the changing lives and subsequent needs of individuals and be respectful of their right to independence, choice and control, highlighting how they will uphold this.

Named Social Workers should understand how social work with adults with learning disabilities can contribute towards reduced health inequalities by improving access to services. They should understand how higher quality care and support can be achieved through providing professional challenge and quality assurance of how support plans contribute towards meeting people's outcomes.

Named Social Workers should understand how upholding people's human rights can lead to reduced risk of poor treatment or abuse within hospital, inpatient and care and support settings. They should contribute towards achieving parity of esteem between mental and physical health by enabling person centred support planning which integrates housing, health, care and support around the person in keeping with their wishes, feelings and preferences.

Named Social Workers should be able to evidence delivery of a more personalised approach towards planning support which upholds people's rights to have their wishes, feelings and

beliefs central to decision making. They should be able to work with providers of support to increase their awareness of the circumstances which would constitute a deprivation of liberty in hospital or for a person living in a supported housing or residential setting.

- **Leadership**

Named Social Workers should be at the forefront of shaping and influencing practice. This should include work with user led organisations to ensure that the views of individuals remain central to and continue to shape adult social work.

Named Social Workers should incorporate creative and flexible ways of working into practice, considering the role of things such as assistive technology, grass roots and charitable organisations and therapeutic approaches that challenge the status quo, offering opportunities to collaborate and work in partnership with people to achieve the life they want.

Named Social Workers should provide supervision, mentoring and training to staff, students, providers and other partner organisations. They should seek to create confident workers who understand their role, have permission to challenge and change and keep pace with a fast moving, dynamic profession.

- **Critical reflexivity and professional challenge**

Named Social Workers should understand how to focus on power dynamics in relationship. They should understand that relationships with individuals are central to their practice and provide critical challenge to other professionals in relationship. They should be confident to do so.

Named Social Workers should be able to offer challenge to professionals through clear understanding of social work as a rights based profession and the role of a social worker to promote and uphold rights, choice and control.

They should utilise critically reflective supervision, incorporating theory, academic literature and CPD to inform and explore both individual case and wider practice and societal issues, seeking to find alternatives that promote choice, rights, autonomy, partnership and control.



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# Halton's transitions protocol

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*Halton Clinical Commissioning Group*

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## **Transition Protocol**

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For children and young people with disabilities and/or complex needs

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**2017 to 2020**

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## Information Sheet

<b>Service area</b>	Health, Education and Social Care Services
<b>Date effective from</b>	March 2017
<b>Responsible officer(s)</b>	Principal Manager, Transition Team, People Directorate (Adult Social Care) Programme Manager (14-19), People Directorate (Education, Inclusion and Provision) Policy Officer, People Directorate (Adult Social Care)
<b>Date of review(s)</b>	March 2018
<b>Status:</b>  <ul style="list-style-type: none"> <li>• <b>Mandatory (all named staff must adhere to guidance)</b></li> <li>• <b>Optional (procedures and practice can vary between teams)</b></li> </ul>	Mandatory
<b>Target audience</b>	All professionals/agencies in Halton supporting young people with disabilities/complex needs in their transition to adulthood
<b>Date of committee/SMT decision</b>	Adult Social Care Senior Management Team: 1 <sup>st</sup> March 2017 People Directorate Senior Leadership Team: 7 <sup>th</sup> March 2017
<b>Related document(s)</b>	As referenced throughout the protocol
<b>Superseded document(s)</b>	Inter-Agency Transition Agreement 2012
<b>Equality Impact Assessment completed</b>	24 <sup>th</sup> February 2017

## Section One: Introduction

**Transition** is a process or period of change. The term can be applied to all young people to describe the stage in their lives when they move from adolescence to adulthood. However, for the purposes of this protocol it refers to children and young people with disabilities and/or complex needs and their journey from children's to adults' health, education and social care services.

It can be a time of excitement and opportunity with young people perhaps leaving school and considering their plans for the future in terms of employment, training or further education. But it can also be a challenging time with feelings of anxiousness particularly for those who rely on support from health and/or social care services.

This protocol sets out Halton's commitment to supporting those young people who may have a need for care and support in adulthood. It describes how the Council will fulfil its duties and responsibilities under current legislation and guidance relating to transition.

In order for transition to be effective, it is vital that a multi-agency approach is taken rather than being restricted to services provided by the Council. It is equally important that young people and their families/carers are fully informed and involved in the process and enabled to have as much choice and control as possible. It is also essential that transition is seen as an evolving process and not a single event.

This protocol is set within the context of the following vision from the Halton Special Educational Needs and/or Disabilities (SEND) Strategy 2016-2020:

*“Our vision is for children and young people with SEND to be included in the planning and development of services; to be provided with information to enable them to participate as fully as possible in decisions so that the personalised support they receive helps them to achieve the best possible aspirational outcomes, preparing them effectively for adulthood, allowing them to be as independent, successful and healthy as possible.”*

### Scope

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This protocol applies to children and young people between the ages of 14 and 25 who have disabilities and/or complex needs, including the following distinct groups:

- Those who have an Education, Health & Care (EHC) Plan (or a Statement of Special Educational Needs);
- Those who are likely to meet the eligibility criteria for adult social care services (in line with the Care Act 2014);
- Those with Continuing Healthcare needs;
- Those with complex needs (e.g. challenging behaviour, learning disabilities, severe autism, acute or chronic medical conditions);
- Those who would benefit from support in planning for adult life but do not have an EHC Plan/SEN (e.g. those with high-functioning autism or social/emotional/mental health difficulties/ill health);
- Carers of young people preparing for adulthood and young carers who are themselves preparing for adulthood.

*This protocol **does not** apply to those young people with mental health conditions, i.e. those being supported by the Council's Mental Health Social Work Teams.*

It is intended that this protocol will provide professionals from all agencies involved in supporting young people through the transition process with information about what should happen and

when, who has responsibility and how agencies should work together. It is aimed at professionals from across education, health and social care, including the following services/organisations:

- Halton Borough Council – Children’s and Adults’ Social Care and Education Services;
- NHS Halton Clinical Commissioning Group;
- Bridgewater Community Healthcare NHS Trust;
- 5 Boroughs Partnership NHS Foundation Trust;
- Schools, colleges and other education providers;
- Other partner agencies, e.g. information and advice providers and advocacy services.

## **Aims and outcomes**

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Against the backdrop of relevant legislation and guidance outlined in subsequent sections, this protocol aims to ensure that in Halton all young people and their families/carers have a positive transition experience.

Success will be evidenced by the following outcomes of good transition:

- Young people making decisions and taking the lead or being supported by people who can advocate for them;
- Young people being supported to plan what they want to do and achieve;
- Young people with care and support needs being able to access the same opportunities as other young people;
- Young people being able to access services that help them;
- Young people being able to try things out and being free to change their mind;
- Young people and their carers telling their story only once;
- Young people and their carers being listened to and fully involved in planning and decision-making;
- Young people and their carers having one key point of contact through the transition process and receiving consistent messages;
- Young people and their carers feeling supported;
- Young people and their carers having access to understandable information;
- Professionals pursuing agreed plans but being flexible to accommodate change as required.

## Section Two: Local processes and procedures

### Transition Team

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In order to fulfil the obligations placed on local authorities under the legislation and guidance outlined in Section Three, Halton Borough Council has established a dedicated Transition Team comprising 3.5 full-time equivalent Social Workers and a Principal Manager.

The Team will facilitate a joined-up approach to transition from across education, health and social care with increased and targeted co-ordination and communication from all agencies starting from Year 9 (age 13/14) up to the age of 25 years or until appropriate to transfer into generic adult services.

The Team will work closely with a range of professionals from across a range of education, health and social care services.

Referrals into the Transition Team will usually be made by schools in preparation for involvement with the annual review meeting in year 9. Other referral routes will include the SEND Service, children's early intervention services, Complex Needs Panel, Transition Operational Group and family members. Referrals should usually be directed via the Council's Contact Centre. New and unexpected entries to the system may also occur (e.g. as a result of someone moving into the area or a young person acquiring an enduring injury during the transition phase) and would be highlighted via the monthly Transition Operational Group meetings or via a referral through the Contact Centre (either from a professional or the individual themselves/their family).

*See Appendix 1 for the CareFirst Transition Recording Process.*

### Transition timetable

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As per the Children & Families Act 2014 (see Section Three for more information), every EHC Plan review from year 9 onwards must have a focus on preparing for adulthood. Transition planning for those young people with SEND takes place as part of the statutory annual review process, which is arranged by both mainstream and special schools and is monitored by the Council's SEND Service.

For those young people at a point of transition, who currently have a Statement of Special Educational Needs, the function of the review meeting will be:

- To discuss progress made by the young person;
- To look at the different options available and discuss the plan for transition;
- To transfer the Statement of Special Educational Needs to an Education, Health and Care Plan.

For those young people who already have an Education, Health and Care Plan, the function of the review meeting will be:

- To discuss progress made by the young person;
- To look at the different options available and discuss the plan for transition;
- To review the Education, Health and Care Plan and the outcomes.

**All reviews are to be conducted in a person centred manner.** Currently, Halton Speak Out is commissioned by the Council to provide a facilitation role in person centred reviews for those with a learning disability and/or complex needs; their involvement should be arranged by professionals as appropriate.

*See Appendix 2 for a flow chart of the Annual Transition Review Process.*

## Year 9

Year 9 (age 13/14) marks the start of the formal transition to adulthood process and at this point the Transition Team will become involved in planning for the transition to adult services.

The review meeting is called by school and the following must be in attendance:

- The young person and their family/carers or chosen representative;
- School staff;
- A member of the Transition Team (Transition Social Worker);
- SEND Team representative;
- Health professionals as relevant (e.g. school nurse and any therapists involved);
- Careers advisor (provided through school), if relevant;
- Person centred facilitator, if relevant.

In advance of the year 9 review, school will support the young person to complete the ‘**My Transition Plan**’ document (see Appendix 3), which will be discussed during the review meeting and added to and updated as appropriate afterwards. The Transition Social Worker will support school staff with this process. The purpose of My Transition Plan is to capture the young person’s aims and aspirations for the future, the options that may be available to them as they move towards adulthood and the care and support they may require.

To assist with transition planning, young people and their families should be referred to the [Preparing for Adulthood section of Halton’s Local Offer](#), which provides information, support and advice across education, health and social care covering ages 0-25 years. In addition, the [Care and Support for You Portal](#) provides information, advice and signposting with regards to adult social care services (age 18+).

My Transition Plan sits alongside the Education, Health and Care (EHC) Plan and the Health Action Plan, which is initiated by the school nurse at year 9, as necessary. Some young people may also have an ‘All About Me’ book, which is produced by schools from year 7 onwards (schools are responsible for maintaining this). Each of these documents will be considered within the review and updated by the relevant professional as appropriate following the meeting. The Transition Social Worker, supported by the relevant school, takes responsibility for the My Transition Plan. The SEND Service has responsibility for the EHC Plan. Health staff in attendance at the review will give consideration to whether the young person needs any therapeutic involvement or if any further referrals need to be made.

## Year 10 to Year 14

An annual review takes place each year and the process is the same as year 9; schools will arrange the review meeting and ensure that all relevant professionals are invited to attend along with the young person and their family/carers (see full list under year 9). The young person’s My Transition Plan, EHC Plan and other documents will be reviewed and updated as appropriate.

There are some additional considerations in **year 11** and **year 14**, as at these times it is possible that the young person may change education provider or finish education. Schools have a statutory responsibility to ensure that young people have access to careers education, information, advice and guidance from year 9 onwards. In years 10 to 14 it is focussed on firming up the options when leaving statutory education. There should be taster sessions offered from the educational setting that the young person is looking to attend post-16 and these will be explored and confirmed by the current setting.

If leaving school or college (year 11/14), the young person’s final School Health Review (to incorporate the Health Action Plan) should be completed by the school nurse or paediatrician and a copy given to the young person/their family and shared with their GP (if consent given). It should also be made available to adult services to inform future health needs.



Annual reviews, with involvement from the Transition Team and review/update of My Transition Plan, will continue to take place post-16 whether the young person remains within the same school or moves to another post-16 education provider. Schools/colleges will arrange review meetings and invite all relevant people as per the list provided under year 9.

### ***Financial considerations***

When a young person reaches age 16, their financial position may change in a number of ways depending on individual circumstances:

- If Personal Independence Payment (PIP, formerly known as Disability Living Allowance or DLA) is being claimed on a young person's behalf, they will be able to claim it in their own right from age 16;
- Some young people may be able to access Employment and Support Allowance and/or Income Support.

The Transition Team, school or other professional (as appropriate) should make a referral to the Welfare Rights Service in order to ensure that the young person is in receipt of the correct benefits.

It may also be necessary for a referral to be made to Welfare Rights as the young person approaches age 18 given the possible changes in income at this time and the fact that they may be required to make a financial contribution to the services they receive from adult social care.

### ***Referrals for those with learning disabilities***

Young people with a learning disability may be eligible for services from the Council's Adult Learning Disability Nursing Team from age 18 (in line with the eligibility criteria at Appendix 4). For those with more complex needs, the ALD Nursing Team may begin their involvement from age 17. The Transition Social Worker should make a referral at the appropriate time; the LD Nurses will then complete an eligibility assessment, Health Action Plan or an alternative piece of work, if required.

The Adult Community Learning Disability Nurse will liaise with child health and paediatric therapy services to establish if there are ongoing interventions that are likely to need to be transferred to adult health services' nursing and therapists. Where necessary, referrals will be made to the appropriate adult health service provider so that any joint working and phased transfer of ongoing intervention required can be facilitated.

Referrals may also be made to the 5 Boroughs Partnership (5BP) Halton Community Learning Disability Team, in line with the eligibility guidance outlined at Appendix 5. The Transition Social Worker should make a referral at the appropriate time.

### ***Equipment considerations***

For those young people who use specialist and adaptive equipment to enhance their function, independence or quality of life, child health services will review that equipment in preparation for early adulthood. This is crucial, as some specialist equipment that was funded for their needs as children is not subsequently funded in adult life.

## ***Age 18-25***

Some young people with special educational needs remain at a statutory school until they are age 19. As part of the review of their Education, Health and Care Plan, the outcomes under Preparing for Adulthood will be reviewed and if it is considered that they have not yet been achieved and further education is required to meet those outcomes, the young person may transition into a further educational placement. Links will also be made with other services such as Day Services and/or the Community Bridge Building Team to identify opportunities to build independence, maintain and improve health and access employment opportunities, if possible. The most appropriate provision should be identified according to the individual needs of the young person.

All adults in receipt of a service from an adult social care team will have a minimum of an annual review to determine continued eligibility for a service.

If young people aged 18 or over have not been included in the transition process as described above for any reason and professionals/parents/young people feel they may meet the criteria for adults' services, they can refer them for an assessment through the Council's Contact Centre. If the outcome of the assessment is that someone is eligible for services from adult social care, they will be met by the appropriate adult social care team.

### *Out of borough schools*

A number of young people attend schools outside the borough; the procedure outlined above applies in the same way with involvement in annual reviews from the Transition Team and monitoring via the SEND Service.

## **Assessment**

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In line with the Care Act, a **transition assessment** will be conducted for young people with care and support needs if they are likely to have needs when they reach age 18. Adult carers of young people preparing for adulthood and young carers who are themselves preparing for adulthood are also entitled to a transition assessment.

The assessment should be carried out when it is of **significant benefit** to the individual, which will differ according to personal circumstances; there is no set time when the assessment should be done and it can be done before the age of 18.

The assessment is separate to the My Transition Plan and looks at levels of need and eligibility for services but, as with transition planning, the assessment must be person-centred and outcome-focussed. It must also be strengths-based and focus on what the individual can do and achieve.

Assessment will be in line with the Care Act and completed as per the adults process through completion of the Supported Assessment Questionnaire (SAQ). Following assessment, application may be made to fund services.

Eligibility for community care services within adult social care will be in accordance with Care Act assessment and eligibility criteria. For more information, consult the Halton Borough Council [Adults Assessment and Eligibility Policy](#) and [Carers Assessment and Eligibility Policy](#), which are available on the Intranet (links are provided to the current version of each policy, which are due for review in April 2017; therefore, please ensure that you consult the most up-to-date version).

Adults who are assessed as eligible for services will also have a financial assessment to determine whether the person will need to make a financial contribution to the services they will receive. This assessment will be in accordance with Halton's [Charging for Residential Care Services Policy](#) and [Fairer Charging for Non-Residential Services Policy](#) (links are provided to the current 2016/17 versions of the policies; please ensure that you consult the most up-to-date versions via the Council's Intranet. Please note that these policies are to be combined into one overall Charging Policy in 2017/18).

Continuing Healthcare assessments will be conducted in accordance with the National Framework outlined in Appendix 6.

## **Funding**

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Throughout the transition process, funding applications will need to be submitted to the relevant funding panel according to the age of the young person (i.e. under 18 or 18+).

If the young person has complex health needs, consideration should be given to Continuing Healthcare (CHC) funding, which will be in line with the National Framework outlined in Appendix 6. The Transition Social Worker should make a referral to the Adult Continuing Healthcare Team (see Appendix 5).

Decisions on funding of education will be aligned to the Education, Health and Care Plans.

## **Personal Budgets / Personal Health Budgets**

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As per the SEND Code of Practice, young people and parents of children who have EHC plans have the right to request a Personal Budget, which may contain elements of education, social care and health funding. A Personal Budget is an amount of money identified by the local authority to deliver provision set out in an Education Health and Care Plan where the parent or young person is involved in securing that provision.

More information is available via the Local Offer using the links below (copy and paste them into your browser):

- Halton Guidance on Personal Budgets for Children with Special Educational Needs and Disability – (September 2014): <https://localoffer.haltonchildrenstrust.co.uk/wp-content/uploads/2014/08/Personal-Budgets-.pdf>
- Children’s & Young People’s (0-25) Personalisation & Personal Budgets Policy (*including Personal Health Budgets and Direct Payments*) Special Educational Needs and Disability (SEND): <https://localoffer.haltonchildrenstrust.co.uk/wp-content/uploads/2016/06/Personal-budgets-Policy-2016.pdf>

Information relating to Personal Budgets for adults is available via the following link:

<http://www3.halton.gov.uk/Pages/adultsocialcare/Budgets.aspx>

*“Personal Budgets are an allocation of funding given to users after an assessment which should be sufficient to meet their assessed needs. Users can either take their personal budget as a direct payment, or – while still choosing how their care needs are met and by whom – leave councils with the responsibility to commission the services. Or they can take have some combination of the two.”*

Also, the adults Personal Budgets Policy can be found on the Council’s Intranet:

- [Personal Budgets – Social Care & Health \(for Direct Payments\) Policy, Procedure & Practice](#)

## **Safeguarding**

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Safeguarding is everyone’s business. If there are any concerns that a young person is at risk of harm or abuse, a report should be made to Child Safeguarding if the person is under the age of 18 or Adult Safeguarding if they are aged 18 plus. More information on how to report a safeguarding concern is available via the following links:

- [Halton Safeguarding Children Board Procedures Manual December 2016](#)
- [Safeguarding Adults in Halton Inter-Agency Policy, Procedures and Good Practice Guidance 2015-2018](#)

## **Operational and strategic oversight**

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There are a number of meeting groups that focus on transition of young people into adult life.

Operationally, transition is managed through the Transition Operational Group, which meets on a monthly basis to track progress of individuals going through transition in order to identify and plan for the needs of young people who are likely to meet the eligibility criteria for adults' social care/health services. The group facilitates referrals and multi-agency involvement and also helps to highlight any new/unexpected entries to the system in a timely manner.

Also at an operational level there is the Preparing for Adulthood Group and the SEND Commissioning Group; the three operational groups work together to feed through recommendations to the SEND Strategic Partnership, the Children's Trust and the All-Age Disability Partnership Meeting in order to effect changes at a strategic level.

Strategic and decision-making responsibility with regards to the Transition Team/matters arising from the Transition Operational Group sits with the Adults' Senior Management Team (SMT), which meets on a weekly basis.

## Section Three: Legislation and guidance

Together, the **Children & Families Act 2014** and the **Care Act 2014** provide a single, comprehensive legislative framework for the transition from children's to adults' services for those with care and support needs.

It is important to note that the Children & Families Act introduced a system of support from birth to 25 years and the Care Act is concerned with those aged 18 or over; therefore, there is a group of young people aged 18-25 who are entitled to support through both pieces of legislation.

The duties from both acts are placed on local authorities, not children's and adults' services separately; therefore, joint working is vital to ensuring smooth transition. Both acts have a shared focus on person-centred and outcome-focussed approaches that involve young people and their carers, recognising that transition is a process experienced as a family rather than an individual. It is also essential that transition is indeed seen as a process evolving gradually from ages 14 to 25, as opposed to a 'cliff-edge' at age 18.

It is also important to note that, with regards to safeguarding, although the Children & Families Act gives rights to young people from the end of compulsory school age, child safeguarding law still applies up to the age of 18. Similarly, the Care Act guidance states that if someone is 18 or over but still receiving children's services and a safeguarding issue is raised, the matter should be dealt with through adult safeguarding but with involvement of children's safeguarding and other organisations as appropriate (e.g. NHS, police).

Displayed below is summary information on the legislation and associated guidance plus links to the full information. There is also a range of good practice and guidance resources provided which will be of assistance to professionals in supporting effective transition from children's to adults' services.

### Children & Families Act 2014 & SEND Code of Practice

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#### Legislation:

<http://www.legislation.gov.uk/ukpga/2014/6/contents/enacted>

Part 3 of the **Children & Families Act** relates to children and young people with special educational needs or disabilities (SEND); it creates a comprehensive 0 to 25 years SEND system with the aim of joining up education, health and care (through EHC Plans) so that services support the best outcomes for children and young people.

#### Associated guidance:

<https://www.gov.uk/government/publications/send-code-of-practice-0-to-25>

The **SEND Code of Practice** provides statutory guidance on duties, policies and procedures relating to Part 3 of the Children & Families Act 2014. It relates to the SEND system for children and young people aged 0 to 25 years. Chapter 8 of the Code of Practice is concerned with 'Preparing for adulthood from the earliest years.'

#### **Key points (consult the legislation/guidance in full for further information):**

- Local authorities must publish a 'Local Offer', which should include advice/information on preparing for adulthood;
- Help should be offered at the earliest possible point – good transition planning starts before age 14 and should include raising aspirations and supporting children to make decisions;

- Young people aged 16 or over have the right to make decisions and requests – professionals must ensure they are prepared and that the implications of the Mental Capacity Act 2005 are considered. Parents should still be involved in decision-making, particularly if the young person is aged under 18;
- Education, Health & Care (EHC) Plans (which replace Statements and Learning Difficulty Assessments) must be person-centred and outcome-focussed. Every EHC plan review from Year 9 onwards must have a focus on preparing for adulthood, which includes support to prepare for higher education/employment, independent living, maintaining good health and participating in society;
- Local authorities may continue EHC plans until the end of the academic year during which the young person turns 25;
- There is a right to request a personal budget as part of the EHC process;
- Carers have the right to an assessment and support (similar to the entitlements offered through the Care Act);
- Schools/colleges should raise the career aspirations of SEN students and provide careers guidance;
- All professionals should support young people with SEN to develop the skills, experience and qualifications they need for employment (e.g. arrange work-based learning opportunities);
- All young people with SEN should be supported to make the transition to life after school/college, whether or not they have an EHC plan;
- To prepare the young person for good health in adulthood, support must be provided for their transition to adult health services. Professionals should work with the young person to develop a transition plan, which identifies a lead care co-ordinator (the young person should know who this is and how to contact them). Clinical Commissioning Groups (CCGs) must co-operate with local authorities in supporting transition to adult services and must jointly commission services that will meet EHC plan outcomes. In supporting transition from Child and Adolescent Mental Health Services (CAMHS) to adult mental health services, CCGs and local authorities should refer to 'The Mental Health Action Plan, Closing the Gap: Priorities for essential change in mental health' (Department of Health, 2014);
- With regards to transition to adult social care, young people with SEN turning 18, or their carers, may become eligible for adult care services, regardless of whether they have an EHC plan or whether they have been receiving care under section 17 of the Children Act 1989. Under the Care Act (see next section), local authorities must carry out a transition assessment where there is significant benefit to a young person/their carer in doing so and they are likely to have needs for care and support from age 18. The transition assessment should be undertaken as part of one of the annual statutory reviews of the EHC Plan and this must be at the right time for the individual (i.e. when it would be of 'significant benefit' – there is no set age);
- Services should work in an integrated manner – co-ordinated, multi-agency support is required if young people are to achieve good life outcomes;
- Under no circumstances should young people find themselves without care and support as they go through transition.

## Care Act 2014 & Care & Support Statutory Guidance

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### Legislation:

<http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted>

The **Care Act** creates a new modern framework for care and support legislation with the central principle of wellbeing. Sections 58-66 of Part 1 of the Care Act deal with 'Transition for children to adult care and support, etc.'

### Associated guidance:

<https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance>

Chapter 16 of the **Care & Support Statutory Guidance** covers 'Transition to adult care and support' (guidance on sections 58-66 of the Care Act).

### *Key points (consult the legislation/guidance in full for further information):*

- The Care Act introduces an entitlement to a **transition assessment** for the following groups if they are likely to have needs once they or the person they care for turns 18 in order to help them plan for transition:
  - Young people under the age of 18 with care and support needs who are approaching transition to adulthood;
  - Young carers under the age of 18 who are themselves preparing for adulthood; and
  - Adult carers of young people who are preparing for adulthood;
- Local authorities have powers to ensure continuity so that for those receiving children's services, they do not abruptly end when the young person turns 18 but must continue until adults' service have a plan in place;
- The transition assessment must be carried out **when there is significant benefit** to the young person or carer in doing so; the most appropriate timing of the assessment will be different for everyone and will depend on circumstances such as upcoming exams, entering college/work, moving out of the family home, planned medical treatment and so on;
- Transition assessments themselves can help with preventing, reducing or delaying the development of care and support needs;
- The transition assessment must be person-centred and outcome-focussed and guided by the principle of wellbeing. It should support the young person and their family to plan for the future by providing them with information about what they can expect. It should consider current needs and likely needs as an adult, including which are likely to be eligible needs;
- The provisions in the Care Act do not relate only to those young people who are already known to the local authority (i.e. those receiving children's services) but also anyone who is likely to have adult care and support needs once they reach age 18 – local authorities need to consider how they will identify such people;
- Successful transition depends on the young person, their carers/family and professionals working together and local authorities have a legal responsibility to ensure effective internal and external co-operation to ensure transition is smooth. Equally, partners of the local authority have a reciprocal duty of co-operation. There is evidence of the value of having a 'named worker' or 'lead professional' to co-ordinate transition and assessment planning across all agencies and local authorities should consider formalising this.

## Mental Capacity Act 2005

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### Legislation:

<http://www.legislation.gov.uk/ukpga/2005/9/contents>

The **Mental Capacity Act (MCA)** applies to people aged 16 and over who may lack the mental capacity to make decisions about their care /treatment/ support.

### Associated guidance:

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/497253/Mental-capacity-act-code-of-practice.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf)

The MCA is supported by practical guidance in the form of the **Code of Practice**.

### *Key points (consult the legislation/guidance in full for further information):*

- A person lacks capacity if they are unable to make a particular decision or take a particular action for themselves at the time the decision or action needs to be taken;
- There should always be a presumption of capacity; all adults (aged 16 or over) should be considered to have the capacity to make a decision themselves unless an assessment proves otherwise. In addition, it may be that they have capacity to make some decisions but not others;
- People should be given help and support to make their own decisions or participate in decision-making;
- Any decision or action taken on behalf of someone who lacks capacity must be in their best interests.

Part 3 of the Children & Families Act outlines that the right to make requests and decisions applies directly to disabled young people and those with SEN over compulsory school age (the end of the academic year in which they turn 16) rather than to their parents. The Preparing for Adulthood factsheet (see link in the following PfA section) includes more information on how young people can be prepared and supported to make decisions themselves and/or take part in decision making.

## NICE guidance

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### *NICE Guideline (NG43) 'Transition from children's to adults' services for young people using health or social care services'*

<https://www.nice.org.uk/guidance/ng43>

This guideline covers the period before, during and after a young person moves from children's to adults' services. It aims to help young people and their carers have a better experience of transition by improving the way it's planned and carried out. It covers both health and social care.

The overarching principles are as follows:

- Young people and their carers should be involved in transition service design, delivery and evaluation;
- Transition support should be developmentally appropriate, strengths-based and person-centred;
- Health and social care service managers in children's and adults' services should work in an integrated manner to ensure that young people experience a smooth transition;
- Service managers in both adults' and children's services across health, social care and education should identify and plan for young people with transition support needs;



- Safeguarding information should be shared as appropriate by all agencies in line with local policy;
- It should be confirmed that the young person has a GP (and consideration should be given to a named GP).

**NICE Quality Standard (QS140) ‘Transition from children’s to adults’ services’**

<https://www.nice.org.uk/guidance/qs140>

This standard is based on guideline NG43 and sets out the following quality statements:

- Statement 1: Young people who will move from children's to adults' services start planning their transition with health and social care practitioners by school year 9 (aged 13 to 14 years), or immediately if they enter children's services after school year 9.
- Statement 2: Young people who will move from children's to adults' services have an annual meeting to review transition planning
- Statement 3: Young people who are moving from children's to adults' services have a named worker to coordinate care and support before, during and after transfer.
- Statement 4: Young people who will move from children's to adults' services meet a practitioner from each adults' service they will move to before they transfer.
- Statement 5: Young people who have moved from children's to adults' services but do not attend their first meeting or appointment are contacted by adults' services and given further opportunities to engage.

**Good practice resources**

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***Preparing for Adulthood (PfA)***

<http://www.preparingforadulthood.org.uk/>

The national Preparing for Adulthood (PfA) programme is funded by the Department for Education (DfE) as part of the delivery support for the SEND reforms. PfA’s vision is that young people with SEND should have equal life chances as they move into adulthood, which should include paid employment and higher education, housing options and independent living, good health, friends, relationships, community inclusion and choice and control over their lives and support.

There are five key messages from PfA:

- Develop a shared vision of improving life chances with young people, families and all key partners;
- Raise aspirations for a fulfilling adult life by sharing clear information about what has already worked for others;
- Develop a personalised approach to all aspects of support using person-centred practices, personal budgets and building strong communities;
- Develop post-16 options and support that lead to employment, independent living, good health, friends, relationships and community inclusion; and
- Develop outcome-focussed multi-agency commissioning strategies that are informed by the voice of young people and families.

These messages are essential to improving life chances in the four outcome areas – employment, independent living, community inclusion and health.

There are a range of resources on the PfA website, including the following useful factsheets:

- [The links between the Children and Families Act 2014 and the Care Act 2014](#)
- [The Mental Capacity Act 2005 and Supported Decision Making](#)

### *Social Care Institute for Excellence (SCIE)*

<http://www.scie.org.uk/care-act-2014/transition-from-childhood-to-adulthood/>

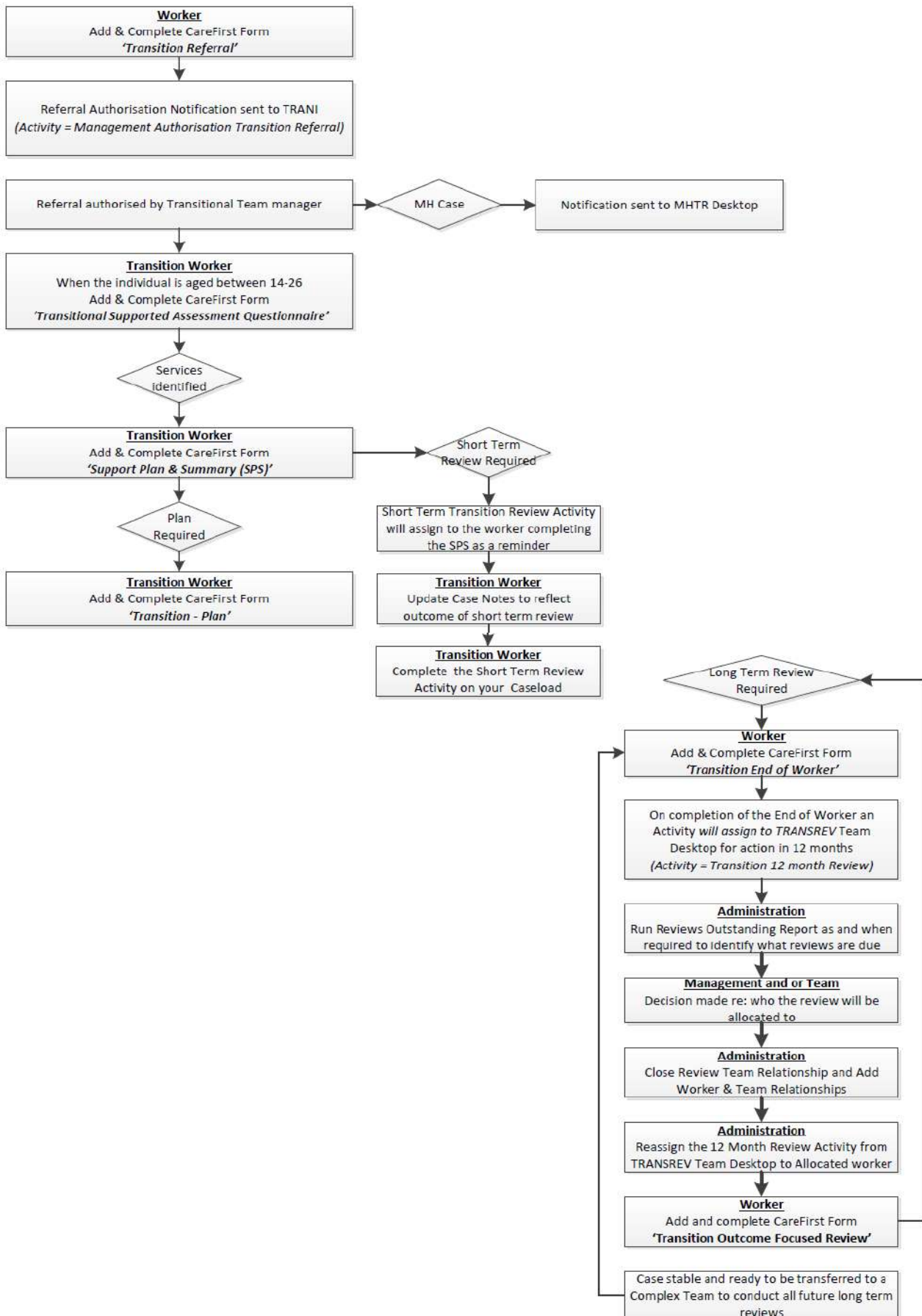
SCIE has developed a range of resources to help local authority staff, social workers, young people and carers to plan for the transition to adult care services.

### *Skills for Care*

<http://www.skillsforcare.org.uk/Standards-legislation/Care-Act/Learning-materials/Transition-to-adulthood.aspx>

Skills for Care has developed a range of learning and development materials to help with the changes brought about by the Care Act 2014, including a specific set of materials on 'transition to adulthood.'

# Appendix 1: Transition CareFirst Recording Process



## Appendix 2: Transition Annual Review Process

### Preparation for the Transition Review Meeting

The following is to take place at least two weeks before the meeting:

- Young person supported by school to complete 'My Transition Plan'
- School to invite relevant people in consultation with the young person/their family, including representatives from; the Council's Transition Team, health services (CAMHS, Therapists), school nurse (for those on CHC)
- School staff to ensure that the young person/their family are fully prepared in advance of the meeting
- School staff to ensure that all required information (relating to their experience and aspirations plus any previous education/health/social care reviews) is gathered and distributed to those invited to the meeting



### Annual Transition Review Meetings:

Year 9  
(age 13-14)

Year 10  
(age 14-15)

Year 11\*  
(age 15-16)

Year 12  
(age 16-17)

Year 13  
(age 17-18)

Year 14  
(age 18-19)



### Consider what assessments and services are required to support adulthood:

- Support with budgets and resources
- Access to leisure and social activities
- Work experience, training, supported employment
- Housing, supported housing, housing advice, adaptations
- Transport, including independent travel training (how will the young person physically get to places?)
  - Assistance with personal care and independent living skills
    - Short breaks
- Referral to welfare rights (at age 16 for support claiming own benefits)

\*At this point (year 11) there needs to be a full assessment of social care needs to determine the appropriate package of support into adulthood – work may need to take place with commissioners to ensure appropriate services are available



### At the Transition Review Meeting:

School to facilitate/chair the meeting and ensure completion and sharing of the review 'My Transition Plan' to be reviewed and updated as necessary by Transition Social Worker

**A named worker for transition to be agreed at the meeting; this person will act as the contact point for the young person and their family for the forthcoming year**

## Appendix 3: My Transition Plan



Halton My Transition  
Plan FINAL.docx

## Appendix 4: HBC ALD Nursing Team Eligibility Criteria



The formal criteria for a diagnosis of 'learning disability' are: significant impairments of both intellectual and adaptive/social functioning, which have been acquired before adulthood (Valuing People, 2001; British Psychological Society, 2001; American Psychiatric Association, 1994; American Association on Mental Retardation, 1992; World Health Organisation, 1992).

Indicators that the person <i>may</i> have a learning disability	Indicators that the person <i>may not</i> have a learning disability
<ul style="list-style-type: none"> <li>• Evidence of delays in reaching developmental milestones e.g. walking/talking.</li> <li>• Previous statements indicating cognitive functioning in the learning disability range (e.g. IQ scores less than 70). <b><i>The onus is on the referrer to locate and send copies of these.</i></b></li> <li>• Attended special school or attended mainstream school with extra support.</li> <li>• Unable to read, write or tell time, or this is limited.</li> <li>• Requires significant support from others for day to day living e.g. home living, use of community facilities, budgeting, personal care.</li> <li>• Unable to work in paid employment without support.</li> <li>• Previously known to learning disability services.</li> <li>• Educational reports refer to 'severe learning difficulties' (often equivalent to mild or moderate learning disability).</li> </ul>	<ul style="list-style-type: none"> <li>• Reached developmental milestones at appropriate time.</li> <li>• No statement, evidence of qualifications e.g. GCSES.</li> <li>• Has a driving licence.</li> <li>• Attended mainstream school and did not struggle.</li> <li>• Able to read/write well and can tell time using analogue clock.</li> <li>• Able to function independently in most areas of day to day living.</li> <li>• Evidence of working successfully in paid employment without support.</li> <li>• Indicators evident, but these can be explained by other factors e.g. mental health difficulties, physical disabilities, drug/alcohol problems, head injury as an adult.</li> <li>• Educational reports refer to 'mild learning difficulty' (less severe than learning disability).</li> </ul>

# Appendix 5: Eligibility Guidance for 5BP Learning Disability Services



5 Boroughs Partnership  
NHS Foundation Trust

in Halton

## Transition Guidance Eligibility guidance for learning disability services

For interventions offered by professions in the team, referrals can be made directly. The following information is aimed as a guide when considering whether the LD team is the correct service for someone. It is aimed to support services to consider who could potentially benefit from LD services however; formal eligibility screening will be conducted by the team if the person is not already known to the service. Eligibility screening will also look at whether the person would be able to access mainstream services and what the need is for input from the team.

Definition of a Learning Disability (Health criteria – World Health Organisation, 1992)

There are three factors for determining the criteria: all three must be met in order for a person to be considered to have a learning disability:

1. *Significant impairment of intellectual functioning* - A significantly reduced ability to understand new or complex information, or to learn new skills, defined as an IQ of less than 70.
2. *Significant impairment of adaptive/social functioning* - A reduced ability to cope independently.
3. *Age of onset before adulthood* – Significant impairments of the above two criteria must have been acquired before 18 years of age.

Factors which <b>MAY</b> indicate that someone does <b>NOT</b> have a learning disability	Factors which <b>MAY</b> indicate someone <b>DOES</b> have a learning disability
<ul style="list-style-type: none"> <li>• Successfully attended mainstream education without support</li> <li>• Gained qualifications (GCSE's)</li> <li>• Recorded IQ above 70</li> <li>• No delays to development of speech or other milestones</li> <li>• Typical development until an accident or head injury post 18 years</li> <li>• Able to manage on work placements with minimal support, particularly those that involve complex skills e.g. use of tills</li> <li>• Able to access the community without support</li> <li>• Able to budget finances to an age appropriate level</li> <li>• Has driving licence or would be capable of completing theory and practical</li> </ul>	<ul style="list-style-type: none"> <li>• Recorded IQ less than 70 before 18 years (N.B there must also be evidence of problems with independent living)</li> <li>• Record of delayed development/ difficulties with social functioning and daily living before 18 years</li> <li>• Requires significant assistance to carry out tasks of daily living (eating/drinking, keeping self- clean, warm and clothed)</li> <li>• Requires significant assistance social/community adaptation (e.g. social problem solving/reasoning) NB need for assistance may be subtle</li> <li>• Evidence of difficulties in a number of areas of function, not explainable by another 'label' e.g. mental health, acquired brain injury, anxiety</li> <li>• Attended special school, or mainstream school with <b>high levels</b> of support</li> <li>• Unable to read and write</li> <li>• Unable to tell the time or locate events in time accurately</li> </ul>

This table should be used as guidance; it is not exhaustive and other factors may be considered when determining eligibility for learning disability services.

Further support can be sought from Halton Community Learning Disability Team.

Address: Bridges Learning Centre, Crow Wood Lane, Widnes, WA8 3LZ. Tel: 0151 495 5302

## Appendix 6: National Framework for Children and Young People’s Continuing Care and Adult NHS Continuing Healthcare

The “National Framework for Children and Young People’s Continuing Care” published by the Department of Health in 2016 sets out a process for assessment and agreement of eligibility for Continuing Care.

Continuing Care for children and young people is needed where a child or young person (under 18) has complex needs which cannot be met from the health services routinely commissioned by NHS Halton Clinical Commissioning Group (HCCG) or NHS England. It has been defined in recent regulations as:

*‘a package of care which is arranged and funded by a relevant body for a person aged 17 or under to meet needs which have arisen as a result of disability, accident or illness.’*

The care needed may be resource intensive, and long-term, with a significant element of nursing care. It may be provided in a number of settings and may involve more than one provider.

Children’s Continuing Care differs from adult NHS Continuing Healthcare which applies to anyone from 18 years of age who needs to be considered for a health funded package of care that will be arranged and funded solely by the NHS. Children and Young people’s Continuing Care should be part of a wider package of care, agreed and delivered in collaboration between health, education and social care. The arrangements for children with special educational needs or disability (SEND) in particular provide a framework for outcomes-focused joint assessments involving different partners across education, health and care, and many children and young people who need Continuing Care will have special educational needs or disability. A decision on whether or not Continuing Care is needed must be informed by a clinical understanding of a child or young person’s condition and an understanding of the way in which their needs affect their lives and those of their family. The emphasis should be on understanding the outcomes which would make the biggest difference to the child or young person and their family, and how health services can support delivery of those aims.

HCCG is responsible for leading the process of identifying the Continuing Care needs of a child or young person in Halton; Continuing Care needs should be identified, and the package of care agreed, as part of a holistic assessment of the child or young person’s needs. The subsequent decision about provision of care is made in collaboration with the child or young person’s health professionals, social care professionals, education professionals and the child/young person and their family.

### **Transition**

As far as possible, the aim of providing continuing care should be to support the move from dependence to independence, with children and young people being enabled to manage their condition themselves with a full understanding of the implications of their condition.

Every child or young person with a package of Continuing Care who is approaching adulthood should have an Education, Health and Care (EHC) Plan which reflects an active transition process to adult or universal services or to a more appropriate specialised or NHS Continuing Care pathway.

Once a young person reaches the age of 18, they are no longer eligible for Continuing Care for children, but may be eligible for NHS Continuing Healthcare, which is subject to legislation and specific guidance. It is important that young people and their families are helped to understand this and its implications right from the start of transition planning.

The Children’s Complex Care Nurse should attend Halton’s transition planning meeting, and share information regarding Children with Continuing Care needs with Adults Services, with parental consent.



It is best practice that future entitlement to adult NHS Continuing Healthcare should be clarified as early as possible in the transition planning process, especially if the young person's needs are likely to remain at a similar level until adulthood.

- At **14** years of age, the young person will be brought to the attention of adult Continuing Care services.
- At **16** years of age, children receiving Continuing Care will be referred to adult services and all screening for NHS Continuing Healthcare will be undertaken using the adult screening tool.
- At **17** years of age, an agreement in principle for adult NHS Continuing Healthcare should have been made so that, wherever applicable, effective packages of care can be commissioned in time for the individual's 18th birthday (or later, if it is agreed that it is more appropriate for responsibility to be transferred then).
- At **18** years of age, full transition to adult NHS Continuing Healthcare or to universal and specialist services should have been made, except in instances where this is not appropriate.

If a young person who receives children's Continuing Care has been determined NHS Halton CCG as not being eligible for a package of adult NHS Continuing Healthcare in respect of when they reach the age of 18, they should be advised of their non-eligibility and of their right to request an independent review, on the same basis as NHS Continuing Healthcare eligibility decisions regarding adults. HCCG should continue to participate in the transition process, in order to ensure an appropriate transfer of responsibilities, including consideration of whether they should be commissioning, funding or providing services towards a joint package of care (for example, to deliver an EHC Plan).

Children and young people eligible for Continuing Care who have a personal health budget may not be eligible for NHS Continuing Healthcare when they reach 18. Although these young people will cease to have a "right to have" a personal health budget, HCCGs can continue to offer services via a personal health budget on a discretionary basis, to support the transition to adult services. Transition should be planned and agreed with the young person and their family or carers in good time to avoid any disruption or delay to implementing a package of care.

Even if a young person is not entitled to adult NHS Continuing Healthcare, they may have certain health needs that are the responsibility of the NHS. In such circumstances, HCCGs should continue to play a full role in transition planning for the young person, and should ensure that appropriate arrangements are in place for services that meet these needs to be commissioned or provided. The focus should always be on the individual's desired outcomes and the support needed to achieve these.

A key aim is to ensure that a consistent package of support is provided during the years before and after the transition to adulthood. The nature of the package may change because the young person's needs or circumstances change. However, it should not change simply because of the move from children's to adult services or because of a change in the organisation with commissioning or funding responsibilities. Where change is necessary, it should be carried out in a planned manner, in full consultation with the young person. No services or funding should be unilaterally withdrawn unless a full joint health and social care assessment has been carried out and alternative funding arrangements have been put in place.

The legal responsibilities for child and adult services overlap in certain circumstances. In developing individual transition plans, partners should be clear where such overlaps occur, and the plans should clearly set out who will take responsibility and why.

It should be noted that regulations state that, in certain circumstances, when a young person in receipt of children's Continuing Care reaches adulthood, the care arrangements should be treated as having been made under the adult Continuing Care provisions. Guidance on the regulations

sets out that young people approaching their 18<sup>th</sup> birthday will require a reassessment of their health and social care needs as part of their transition planning and that, wherever possible, these young people should continue to receive their healthcare on an unchanged basis until they have been reassessed.

The Children's Complex Care Nurse, the LA Lead and the Complex Needs Panel should monitor and actively participate in the reviews of those recipients of Continuing Care who are approaching adulthood.

The regulations and guidance for NHS Continuing Healthcare can be found at:

<https://www.gov.uk/government/publications/national-framework-for-nhs-continuing-healthcare-and-nhs-funded-nursing-care>

## Glossary

Term	Definition
<b>CAMHS</b>	Child and Adolescent Mental Health Services
<b>CCG</b>	Clinical Commissioning Group
<b>CHC</b>	Continuing Healthcare
<b>EHC Plan</b>	Education, Health & Care Plan
<b>Local Offer</b>	Published by all local authorities to detail in one place the services available in the area for children and young people up to age 25 with SEND.
<b>NICE</b>	National Institute for Health and Care Excellence
<b>Outcomes</b>	Refers to what someone would like to achieve or happen (e.g. being able to go out and about); individuals have the right to say which outcomes are important to them and be supported to achieve them.
<b>Person centred reviews</b>	Puts the person at the heart of the review and explores what is happening from the person's perspective and from other people's perspectives.
<b>Personal Budget</b>	Money that is allocated by local authorities from adult social to pay for assessed care and support needs. The authority can arrange services or the money can be taken as a direct payment and the individual can arrange their own services.
<b>Personal Health Budget</b>	As above but relates to health care/services and the money is provided by the NHS.
<b>SCIE</b>	Social Care Institute for Excellence
<b>SEN</b>	Special Educational Needs
<b>SEN Statement</b>	Being replaced by EHC Plans
<b>SEND</b>	Special Educational Needs and Disability
<b>Strengths based assessment</b>	An assessment focusing on a person's strengths and what they are able to do, not what they can't do.

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# Sheffield's NSW practice framework

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**FUTURE OPTIONS TEAM**  
**Adult Services**  
People's Portfolio



**Practice Framework**

## Practitioner role: Safeguarding

	<p>Social workers must be able to recognise the risk indicators of different forms of abuse and neglect and their impact on individuals, their families or their support networks and should prioritise the protection of children and adults in vulnerable situations whenever necessary. This includes working with those who self-neglect.</p> <p>Social workers who work with adults must take an outcomes-focused, person-centred approach to safeguarding practice, recognising that people are experts in their own lives and working alongside them to identify person centred solutions to risk and harm. In situations where there is abuse or neglect or clear risk of those, social workers must work in a way that enhances involvement, choice and control as part of improving quality of life, wellbeing and safety. Social workers should take the lead in managing positive interventions that prevent deterioration in health and wellbeing; safeguard people (who may or may not be socially excluded) at risk of abuse or neglect, or who are subject to discrimination, and to take necessary action where someone poses a risk to themselves, their children or other people. Social workers who work with adults must be able to recognise and take appropriate action where they come across situations where a child or young person may be at risk. Social workers should understand and apply in practice personalised approaches to safeguarding adults that maximise the adult's opportunity to determine and realise their desired outcomes and to safeguard themselves effectively, with support where necessary.</p>	
<b>Level</b>	<b>Examples of quality of work at this level</b>	<b>Evidence</b>
Inadequate	<ul style="list-style-type: none"> <li>• No follow-up to screening enquiries</li> <li>• No risk identification</li> <li>• No evidence of analysis of risk</li> <li>• No safety planning for the vulnerable adult carer/s during the life of the case or after it has ended</li> <li>• No referral where needed or no follow-up</li> <li>• Vulnerable adult's own perception of risk not ascertained</li> <li>• Safeguarding issues, including domestic violence, not recognised or assessed</li> </ul>	Case file CMS log of initial safeguarding checks

	<ul style="list-style-type: none"> <li>• No feedback to the referrer</li> <li>• Not enough information gathered at screening stage that causes delays in the process</li> <li>• No evidence of client views in the report</li> <li>• No advocate identified where clients lack capacity</li> </ul>	
Satisfactory	<ul style="list-style-type: none"> <li>• Evidence of safe practice e.g. being alert to immediate safeguarding issues</li> <li>• Basic screening checks followed up</li> <li>• Risk identification completed</li> <li>• Limited cross reference to risk factors in the case plan</li> <li>• Vulnerable adult welfare (protection) referrals made and followed up</li> <li>• Some evidence of referral for needs</li> <li>• Evidence that vulnerable adult's perception of risk understood</li> <li>• Some evidence of learning from adult protection research and serious case reviews</li> </ul> <p>Response to risk and safety planning fully embedded within the case plan</p>	
Good	<p>As for satisfactory, plus:</p> <ul style="list-style-type: none"> <li>• Constructive multi-agency engagement building on referrals where needed</li> <li>• Creative solutions within the safety assessment</li> <li>• Application of learning from recent training in risk assessment</li> <li>• Clients outcomes identified throughout the report</li> <li>• <b>Use of appendices to back up findings of the report</b></li> <li>• Appropriate referrals have been made</li> </ul>	
Outstanding	<p>As for good, plus:</p> <ul style="list-style-type: none"> <li>• Evidence of multi-agency engagement which maintains constructive ongoing relationships with relevant agencies and that benefits the individual vulnerable adult</li> <li>• Evidence based assessment</li> <li>• Use of research</li> <li>• Risk assessment has been reviewed and actions have been followed</li> </ul>	

**Practitioner role: Person centred conversations and planning (AQ/RQ/Support Planning)**

	<p>Social workers should enable people to access the advice, support and services to which they are entitled. They should coordinate and facilitate a wide range of practical and emotional support, and discharge legal duties to complement people's own resources and networks, so that all individuals (no matter their background, health status or mental capacity), carers and families can exercise choice and control, (supporting individuals to make their own decisions, especially where they may lack capacity) and meet their needs and aspirations in personalised, creative and often novel ways. They should work co-productively and innovatively with people, local communities, other professionals, agencies and services to promote self-determination, community capacity, personal and family reliance, cohesion, earlier intervention and active citizenship. Social workers should also engage with and enable access to advocacy for people who may require help to secure the support and care they need due to physical or mental ill-health, sensory or communication impairment, learning disability, mental incapacity, frailty or a combination of these conditions and their physical, psychological and social consequences.</p> <p><b>Effective assessments and outcome based support planning</b></p> <p>In undertaking assessments, social workers must be able to recognise the expertise of the diverse people with whom they work and their carers and apply this to develop personalised assessment and care plans that enable the individual to determine and achieve the outcomes they want for themselves. The social worker must ensure the individual's views, wishes and feelings (including those who may lack mental capacity) are included as part of their full participation in decision making, balancing this with the wellbeing of their carers. Social workers should demonstrate a good understanding of personalisation, the social model of disability and of human development throughout life and demonstrate a holistic approach to the identification of needs, circumstances, rights, strengths and risks. In particular, social workers need to understand the impact of trauma, loss and abuse, physical disability, physical ill health, learning disability, mental ill health, mental capacity, substance misuse, domestic abuse, aging and end of life issues on physical, cognitive, emotional and social development both for the individual and for the functioning of the family. They should recognise the roles and needs of informal or family carers and use holistic, systemic approaches to supporting individuals and carers. They should develop and maintain knowledge and good partnerships with local community resources in order to work effectively with individuals in connecting them with appropriate resources and</p>	
<p><b>Level</b> Inadequate</p>	<p><b>Examples of quality of work at this level</b></p> <ul style="list-style-type: none"> <li>No evidence of enabling people to access the advice, support and services to which</li> </ul>	<p><b>Evidence</b> Case files</p>



	<p>they are entitled.</p> <ul style="list-style-type: none"> <li>• Support to individuals to make their own decisions, especially where they may lack capacity, not evidenced</li> <li>• No identification of people's resources and networks or evidence of support to individuals, carers and families to exercise choice and control, to meet their needs and aspirations in personalised, creative way</li> <li>• No case plan or case plan incomplete</li> <li>• Case plan not adhered to</li> <li>• A plan to address the meaning of diversity for the vulnerable adult and family not included</li> <li>• Enquiries to be undertaken unclear and not followed up</li> <li>• No consideration of how risk and safety issues will be addressed</li> <li>• Adult service users not involved in contributing to the case plan</li> <li>• Vulnerable adults not involved in contributing to the case plan</li> <li>• No advocate involved where adult lacks capacity</li> <li>• No clear plan as to how the support will be provided</li> <li>• Costs being incorrect/unclear</li> <li>•</li> </ul>	
Satisfactory	<ul style="list-style-type: none"> <li>• Support to individuals to make their own decisions, especially where they may lack capacity evidenced in case records</li> <li>• People's resources and networks identified and support offered to individuals, carers and families to exercise choice and control, to meet their needs and aspirations in personalised, creative way recorded on file</li> <li>• Evidence of enabling people to access the advice, support and services to which they are entitled.</li> <li>• Case plan on all files but not always completed</li> <li>• Vulnerable adult's views, risk factors and diversity issues included</li> <li>• Case plans specify the key issues, the steps to address those issues, the outcome to be achieved and how the plan will be reviewed</li> <li>• Key enquiries listed</li> <li>• Some evidence of practice, reflection and analysis</li> <li>• Case plans signed off as satisfactory by the manager</li> <li>• Evidence of use of advocates where appropriate</li> </ul>	
Good	<p>As in satisfactory, plus:</p> <ul style="list-style-type: none"> <li>• Case plan routinely provides reflection and a clear analysis of the work to be undertaken</li> </ul>	

	<ul style="list-style-type: none"> <li>• Identified desired outcomes for the vulnerable adult at the centre of the plan</li> <li>• Clear language</li> <li>• Plan regularly reviewed and amended in response to new information, including service user feedback</li> <li>• Appropriate referrals have been made and information gathered from them has been used in the planning</li> <li>• Use of community resources included in the plan where appropriate</li> </ul>	
Outstanding	<p>As in good, plus:</p> <ul style="list-style-type: none"> <li>• Use of research and theory to inform planning</li> <li>• Creative use of other resources beyond the individual worker to benefit the service user</li> <li>• Planning takes place for content of individual interviews</li> <li>• Case plans written for sharing with service users</li> <li>• Case plan specifies key issues/questions to be pursued</li> <li>•</li> </ul>	

<b>Practitioner role: Analysis &amp; Reporting to Court</b>		
<b>Level</b>	<b>Examples of quality of work at this level</b>	<b>Evidence</b>
Inadequate	<ul style="list-style-type: none"> <li>• Correct templates not used</li> <li>• Inaccuracies in personal information re: service user e.g. vulnerable adult's name misspelt, wrong date of birth</li> <li>• Information included in reports which is not relevant to the vulnerable adult's needs or the issues before the court</li> <li>• Recommendations do not flow from analysis</li> <li>• Practitioner fails to analyse information to facilitate decision making in the best interests of the vulnerable adult</li> <li>• Report shows no understanding of the vulnerable adult's individual needs including diversity issues such as identity</li> <li>• Reports not filed on time</li> <li>• Incorrect information in the report</li> <li>• Information in the report is out of date and has not been updated to reflect the current situation</li> </ul>	Case file, including the case plan and previous Reports

Satisfactory	<ul style="list-style-type: none"> <li>• Correct templates used</li> <li>• Reports provide clear and succinct assessments which enable the court to make person centred decisions</li> <li>• Evidence of pro-active case planning which minimises delay</li> <li>• Reports to court, written and verbal, contribute to the court's ability to deliver effective case management and person centred decisions</li> <li>• Practitioner analyses information to facilitate decision making in the best interests of the vulnerable adult</li> <li>• Report shows an understanding of the vulnerable adult's individual needs and desired outcomes</li> <li>• Recommendations including interim case management recommendations flow from analysis</li> <li>• Recommendations shared with service users and their families, advocates and carers where appropriate</li> </ul>	
Good	<ul style="list-style-type: none"> <li>• Each report adds significantly to the court's ability to make decisions which lead to improved outcomes for vulnerable adults</li> <li>• Verbal reports to court, intervention at directions hearings and final verbal evidence in court is of high calibre and influences outcomes significantly</li> <li>• In complex cases the practitioner presents a number of options to the court, discussing coherently the benefits and disadvantages of each and arriving at the reasoned conclusion</li> <li>• Report contents as well as recommendations shared with service users</li> </ul>	
Outstanding	<p>As in good plus:</p> <ul style="list-style-type: none"> <li>• Practitioner routinely uses or refers to validated research to support the recommendations in reports</li> <li>• Adds value to the organisation by promoting/disseminating good practice</li> </ul>	

<b>Practitioner role: Engaging with Vulnerable Adult</b>		
	Social workers must have a thorough knowledge and understanding of the Mental Capacity Act (MCA) and Code of Practice and be able to apply these in practice. They should always	

begin from the presumption that individuals have capacity to make the decision in question. Social workers should understand how to make a capacity assessment, the decision and time specific nature of capacity and hence the need to reassess capacity appropriately. They should know when and how to refer to a Best Interest Assessor.

Social workers must understand their responsibilities for people who are assessed as **lacking capacity at a particular time** and must ensure that they are supported to be involved in decisions about themselves and their care as far as is possible. Where they are unable to be involved in the decision-making process decisions should be taken in their best interests following consultation with all appropriate parties, including families and carers. Social workers must seek to ensure that an individual's care plan is the least restrictive possible to achieve the intended outcomes.

Social workers have a key leadership role in modelling to other professionals the proper application of the MCA. Key to this is the understanding that the MCA exists to empower those who lack capacity as much as it exists to protect them. Social workers must model and lead a change of approach, away from that where the default setting is "safety first", towards a person-centred culture where individual choice is encouraged and where the right of all individuals to express their own lifestyle choices is recognised and valued.

In working with those where there is no concern over capacity, social workers should take all practicable steps to empower people to make their own decisions, recognising that people are experts in their own lives and working alongside them to identify person-centred solutions to risk and harm, recognising the individual's right to make "unwise" decisions.

Social workers need to be able to work directly with individuals and their families through the professional use of self, using interpersonal skills and emotional intelligence to create relationships based on openness, transparency and empathy. They should know how to build purposeful, effective relationships underpinned by reciprocity. They should be able to communicate clearly, sensitively and effectively, applying a range of best evidence-based methods of written, oral and non-verbal communication and adapt these methods to match the person's age, comprehension and culture. Social workers should be capable of communicating effectively with people with specific communication needs, including those with learning disabilities, dementia, people who lack mental capacity and people with sensory impairment. They should do this in ways that are engaging, respectful, motivating and effective, even when dealing with conflict - whether perceived or actual - anger and resistance to change. Social workers should have a high level of skill in applying evidence-based, effective social work approaches to help service users and families handle change, especially where individuals and families are in transition, including young people moving to adulthood,

	supporting them to move to different living arrangements and understanding the impact of loss and change.	
<b>Level</b>	<b>Examples of quality of work at this level</b>	<b>Evidence</b>
Inadequate	<ul style="list-style-type: none"> <li>• Vulnerable adult routinely not being seen, no direct work with service user</li> <li>• Vulnerable adult not being informed of processes and progress</li> <li>• No evidence of the vulnerable adult's overall needs, wishes, feelings and desired outcomes in case file</li> <li>• The diversity needs of the vulnerable adult not identified and considered in support planning or analysis.</li> <li>• Vulnerable adult not informed about the Complaints Procedure</li> <li>• Vulnerable adult not regularly reviewed</li> <li>• Client record not been updated and information is incorrect</li> <li>• Capacity of the vulnerable adult has not been assessed and decisions have been made without involving them or an advocate</li> </ul>	Case file Observation of direct work
Satisfactory	<ul style="list-style-type: none"> <li>• Vulnerable adult routinely being seen, direct work part of standard approach, including sensitive communication facilitated through appropriate tools</li> <li>• Vulnerable adult informed of process, information leaflets given and purpose of social worker role explained</li> <li>• Evidence of the vulnerable adult's overall needs, wishes and feelings in case file</li> <li>• Details of vulnerable adult's needs identified through observations</li> <li>• The diversity needs of the vulnerable adult are identified and considered in the case plan or analysis</li> <li>• Vulnerable adult (with capacity) informed about feedback opportunity and complaints procedure</li> <li>• Information shared by the vulnerable adult is acted upon in accordance with the vulnerable adult's needs, wishes and feelings</li> <li>• Safe and sensitive management of the vulnerable adult's information according to record keeping policy and any specific risks to the individual</li> <li>• Vulnerable adult is informed when work is complete</li> <li>• Vulnerable adult's ongoing support needs are assessed and reviewed within specified timescales</li> <li>• Appropriate advocacy is sourced and used</li> </ul>	

	<ul style="list-style-type: none"> <li>•</li> </ul>	
Good	<ul style="list-style-type: none"> <li>• Appropriate vulnerable adult participation is evidenced, including evidence that information about process and progress towards achieving outcomes is shared with the vulnerable adult.</li> <li>• Use of a wide range of methods to promote the vulnerable adult to express their views and feelings about their situation</li> <li>• Evidence of interview planning prior to meeting and purposeful meetings with the vulnerable adult using appropriate communication tools</li> <li>• Full analysis of the vulnerable adult's situation in AQ/RQ/Support Plan</li> <li>• In consultation with the vulnerable adult and their carers offer/broker support to the vulnerable adult from in-house and external agencies</li> <li>• Promotes relationships with important family members and relatives to sustain the vulnerable adult's long term wellbeing</li> <li>• Need for advocacy / legal representation considered, in partnership with the vulnerable adult</li> <li>• Records shared with vulnerable adult where they directly relate to them and where this accords with their understanding</li> </ul>	
Outstanding	<p>As in good, plus:</p> <ul style="list-style-type: none"> <li>• Development of practice in response to service user feedback</li> <li>• Inform the vulnerable adult on how they can get involved in positive co-production activities to promote consultation in local service developments; local recruitment and selection and focus groups on specific subject areas to inform practice</li> <li>• Involvement in development of vulnerable adult engagement, policy and practice</li> <li>• Creative work with individuals</li> </ul>	

### Practitioner role: Record keeping

Level	Examples of quality of work at this level	Evidence
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Inadequate	<ul style="list-style-type: none"> <li>• Contact log incomplete – no clear record of actions in the case</li> <li>• Entries in records unclear to reader</li> <li>• Key documents missing e.g. Capacity Assessments and Comprehensive minutes of Best Interest Meetings</li> <li>• Data protection and security procedures not followed</li> <li>• Information is incorrect or out of date</li> <li>• Information is recorded on the wrong form</li> <li>• Inappropriate information is recorded</li> </ul>	Case file
Satisfactory	<ul style="list-style-type: none"> <li>• Contact log complete and chronology of case up to date</li> <li>• Content of each meeting provided in case record</li> <li>• Vulnerable adult's views and diversity issues included</li> <li>• Records are clear and succinct</li> <li>• Information recorded on the correct forms</li> <li>• Contact details for all people involved with the care are correct and easily accessible</li> <li>•</li> </ul>	
Good	<p>As in satisfactory, plus:</p> <ul style="list-style-type: none"> <li>• Records of meetings provide evidence of purposeful activity and practitioner analysing information on an ongoing basis</li> <li>• All calls logged fully</li> <li>• Records including AQ/RQ and Support plans written for sharing with service users</li> </ul>	
Outstanding	<p>As in good, plus:</p> <ul style="list-style-type: none"> <li>• Vulnerable adult's own words clearly distinguished</li> <li>• Notes show structure, planning and purpose of each meeting</li> <li>• Progress of case easy to see</li> <li>• Vulnerable adult's needs come alive through the case file</li> </ul>	

**Practitioner role: Professional behaviour**

	<p><b>Supervision, critical reflection and analysis</b>  Social workers must have access to regular, good quality supervision and understand its importance in providing advice and support. They should know how and when to seek advice from a range of sources including named supervisors, senior social workers and other professionals. They should be able to make effective use of opportunities to discuss, reflect upon and test multiple hypotheses, the role of intuition and logic in decision making, the difference between opinion and fact, the role of evidence, how to address common bias in situations of uncertainty and the reasoning of any conclusions reached and recommendations made, particularly in relation to mental capacity, mental health and safeguarding situations. Social workers should have a critical understanding of the difference between theory, research, evidence and expertise and the role of professional judgement. They should use practice evidence and research to inform the complex judgements and decisions needed to support, empower and protect their service users. They should apply imagination, creativity and curiosity to working in partnership with individuals and their carers, acknowledging the centrality of people’s own expertise about their experience and needs.</p> <p><b>Organisational context</b>  Social workers working with adults should be able confidently to fulfil their statutory responsibilities, work within their organisation’s remit and contribute to its development. They must be understand and work effectively within financial and legal frameworks, obligations, structures and culture, in particular Human Rights and Equalities legislation, the Care Act, Mental Capacity Act, Mental Health Act and accompanying guidance and codes of practice. They must be able to operate successfully in their organisational context, demonstrating effective time management, caseload management and be capable of reconciling competing demands and embrace information, data and technology appropriate to their role. They should have access to regular quality supervision to support their professional resilience and emotional and physical wellbeing. Social workers should work effectively and confidently with fellow professionals in inter-agency, multi-disciplinary and inter-professional groups and demonstrate effective partnership working particularly in the context of health and social care integration and at the interface between health, children and adult social care and the third sector.</p>	
<b>Level</b>	<b>Examples of quality of work at this level</b>	<b>Evidence</b>
Inadequate	<ul style="list-style-type: none"> <li>• Examples of service users treated with disrespect</li> <li>• Pattern of complaints from service users about the worker’s behaviour and attitudes</li> </ul>	Manager records 360°



	<ul style="list-style-type: none"> <li>• Breaches of confidentiality</li> <li>• No interest in training or development</li> <li>• Fails to attend training either mandatory or identified as part of Professional Development Plan</li> <li>• Negative comments about the organisation to other agencies</li> <li>• Colleagues treated with disrespect</li> <li>• Acting in a discriminatory way or condoning this in others</li> <li>• Lack of courtesy, respect and professionalism in verbal, written and other forms of communication between workers and other employees</li> <li>• Bringing the organisation into potential disrepute</li> <li>• Wilful refusal to follow reasonable management instruction</li> <li>• Makes no effort to ensure practice is up to date with developments in social work</li> <li>• Turning up late/cancelling meetings without informing others</li> <li>•</li> </ul> <p>Note: some of these behaviours could be sufficiently serious to invoke Performance and Conduct or Dignity at Work procedures</p>	<p>feedback Staff survey</p>
<p>Satisfactory</p>	<ul style="list-style-type: none"> <li>• Worker presents positively to external agencies</li> <li>• Confidentiality respected</li> <li>• Works openly and positively with colleagues</li> <li>• Respects diversity and different cultures and values</li> <li>• Attendance at required training but limited demonstrated interest in wider learning and development</li> <li>• Worker accepts feedback from complaints</li> <li>• The ability to reflect on legitimate concerns raised about performance and work constructively to rectify these with appropriate support from management</li> <li>• Practice is up to date with developments in social work</li> </ul>	
<p>Good</p>	<p>As in satisfactory, plus:</p> <ul style="list-style-type: none"> <li>• Positive feedback from vulnerable adults on the worker's behaviour</li> <li>• Shows a positive willingness to learn from complaints and other feedback</li> <li>• 360° feedback demonstrates that the worker is supportive to colleagues</li> <li>• Worker seeks out learning opportunities</li> <li>• Positively challenges discriminatory behaviour in colleagues or other professionals</li> <li>• Showing leadership in promoting engagement</li> </ul>	

Outstanding	As in good, plus: <ul style="list-style-type: none"><li>• Worker seen as “ambassador” by other agencies</li><li>• Acts as positive mentor for colleagues/new staff</li><li>• Worker seeks contact with other agencies to learn from others and contribute to their development</li><li>• Worker seeks feedback from others and reviews their own performance</li><li>• Actively promotes equal opportunities and diversity for service users</li></ul>	
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**Named social workers –  
better social work for  
learning disabled people**

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## Named social workers – better social work for learning disabled people

An article co-authored by the Bradford NSW team is available online at:

[www.tandfonline.com/doi/abs/10.1080/09687599.2017.1340019](http://www.tandfonline.com/doi/abs/10.1080/09687599.2017.1340019)

# APPENDIX

## Putting people back at the heart of social work

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