Transitions Team - Case Examples for Scrutiny Report November 2017

NB. All names have been changed

Zara Shan

Age 18

Zara was supported by the Children's Complex Health and Disability Team (CHDT) from 2014 as a Child In Need. She has had the same social worker since then. The social workers in now part of the new 14 to 25 Transition Team so will remain involved with Zara post eighteen until she transitions into adulthood. Over the past three years Zara and her family have got to know the social worker well and vice versa.

Zara has a hereditary condition and Sensory Motor Neuropathy type 3 which is a rare condition, she was diagnosed with this condition from birth it is a degenerative abnormality in the nervous system. This condition affects Zara's nerves and senses which means that she does not always respond to pain. Zara is a wheelchair user; the condition also has an impact on her memory and her learning. Zara's muscles are also affected which means that she has a bladder weakness and she wears incontinence garments.

Zara has a support plan for assistance with personal care and social inclusion. She employs Personal Assistant's (PA's) for this.

A Care Act Assessment has now been completed by the same worker who already knows her well, so the family have not had to repeat their story. As Zara's needs meet Care Act eligibility thresholds her support plan has remained the same with no change of provider. The social worker has been able to support Zara and her parents to consider Zara's changing needs as a young adult and her PA supports her to access age appropriate social activities with her peers in her local community. Zara and her family have a good relationship with her social worker which has enabled Zara and Mum to build trust and confidence with the social worker. This has supported good communication and open discussion about planning for the future and positive risk taking. It has also enabled Mum to disclose difficulties she has faced in her personal life which at times has affected her ability to fully care for Zara, this has resulted in the right support being in place for Zara, which in turns has greatly improved both Mum and Zara's quality of life.

Zara does have several complex health needs and she has a Transitions Nurse who is supporting her transfer from her Children's paediatrician to the care of her GP and other specialist consultants. The social worker has been able to liaise with the nurse and also support Zara and the family to understand these changes. The social worker has completed the initial assessment process for health funding, which she is not currently entitled to, however this will be monitored and reapplied for as appropriate.

The social worker will stay involved with Zara until she has left education and transitioned into adulthood. Zara is very creative and would like to pursue college and employment opportunities in the arts. Her social worker will attend school (EHCP) reviews and be part of a multi-agency team supporting Zara to pursue her aspirations.

Elaine Booth

Age 17

Looked After Young Person- fully LAC in 2015 due to parents inability to care for her

Elaine has a complex seizure disorder. At the age of six, she was diagnosed with frontal lobe epilepsy. This type of epilepsy can be very difficult to manage and she has therefore trialled a number of medications, unfortunately her seizures have not responded sufficiently to stabilize her. Elaine has six types of seizures. Type 1 is absence seizures, which can occur at any time. She will stop what she is doing, may stare and be unresponsive which can last a number of seconds. Elaine may need prompting to resume the activity she was involved with prior to the seizure. Type 2 is focal motor seizures, which are one off seizures that can come in clusters or be prolonged. Elaine will present with facial grimacing, strange behaviour and staggers around. Type 3 is focal sensory seizures, which are also one off and can come in clusters or be prolonged. Elaine will present with sudden screaming and seeks reassurance as she is scared. Type 4 and 5 are tonic and tonic clonic seizures, which are more serious and mean that Elaine's limbs will stiffen and she will become unresponsive. Elaine will be at risk of injury and aspiration. She may stop breathing and turn blue. Type 6 is clinical activity seizures where Elaine can experience periods of appearing scared, with her behaviour becoming erratic and unpredictable. Possible triggers of all Elaine's seizures are illness and/or tiredness

Elaine has lived away from Bradford for several years, attending specialist residential epilepsy schools. She has this year moved from a school in the south of the country to a six form school in Lancashire. Since moving to the new school Elaine has come on in leaps and bounds, her confidence is growing and her motivation to achieve things for herself has flourished. She is starting to believe she might be able to have an independent future and is keen to learn and progress. Elaine’s epilepsy remains complex and risky; she will need support to minimise the risks and achieve her dreams.

Elaine has difficulty trusting people, establishing relationships and coping with change as she has had lot of significant upheaval in her life. Elaine now has a good relationship with her social worker and trusts her. The social worker is visiting Elaine at school and starting to have conversations with her about her aspirations for adulthood. Elaine has always maintained contact with her family and she has told her social worker she would like to return to live in Bradford so she can be near to her family.

The school placement is currently joint funded by Education and Health, the social worker has already starting liaising with Transitions colleagues in Education and Health about Elaine’s wishes to return to Bradford when she finishes school and Elaine is included in commissioning and housing data for future supported living requires for the district. The social worker has also starting completing Elaine’s Care Act Assessment and will trigger her assessment for Continuing Health Care as part of this process. The appropriate transitions workers will support Elaine and the school to plan for her move back to Bradford in a planned way over the next eighteen month.

Elaine's mother has always been very anxious about future plans for Elaine, which have at times affected her mental health. However earlier discussions with the social worker in respect of advice and information about Elaine's future prospects have reassured Mum, who will be keen to be part of the planning. Having the same social worker who knows her well, who understands the Children's legislation and procedures as well as the Adults and also has a good knowledge of other transitional services, will make a significant difference to Elaine and her Mum as she transitions into adulthood.

CETR Example

Adam Iqbal

Age 16

Adam has a diagnosis of Autism, Bi-Polar (recently been diagnosed in April 2017), Crania Synopsis which is a condition where there is fusion in the skull, diagnosis of Learning disability and developmental delay. He also has epilepsy and has reduced vision. Adam has Chromosomal Abnormality which is the deletion of chromosome 16 and has Atrial Spectral Defect (ASD) which means that Adam has a hole in the heart. Adam is seen by a number of different professionals and is currently being seen by a Consultant Paediatrician and a Consultant Child Psychiatrist.

Adam has frequent epileptic absent seizures. His anticonvulsant medication has recently been changed in an attempt to bring these seizures under control. He has not had any tonic clonic seizures. Adam has reduced vision in both eyes and is prescribed glasses to correct this. He is up to date with all other medical appointments.

Adam struggles with any change in his routine therefore he finds it very difficult to get back into a routine after the school holidays. This has often lead to parents physically taking him to school.

Historical Information:
The family have been known to Social Care since 2011, the initial referral was made by his mother reporting difficulty in managing Adam's behaviours and sleep.

Between 2011-2013 specialist behaviour support and sleep support was provided by the Children's' Community Support Team (CCST) and inclusion activities were identified; following this there was no further action required by the social care for some time.

In April 2013 Adam's mother contacted Social Care requesting support, she reported that Adam's behaviours had deteriorated. He was presenting challenging behaviours at home and school. An assessment was completed, the outcome was that parents needed support to prevent carer breakdown, Adam required social stimulation and a referral to CAHMS was required.

The family were provided 10hours a week agency support, this then transferred to Adam having respite provision at a Respite unit of one tea visit per week.

Since Social Care involvement Adam has had a number of very difficult periods whereby his anxiety level has heighted to a level that has become extremely challenging for parents to manage. Each time the episodes have lasted for 4/6 weeks. During these periods Adam has refused to leave the house, refused to go to school, has not slept, has displayed with very

distressing behaviours such as, head banging, nipping, hitting, crying, rocking and induced vomiting.

Transition Team Involvement:
Adam was originally supported by the Complex Disability Team. As he is now over 14 he is being supported by the Transitions Team, the worker who supports him now works in Transitions so he has been supported by the same worker and manager for some time. He will now be supported through his transition into Adult services by the same worker, therefore there will be consistent management oversight and consistent worker who has known Adam very well and has a good insight into his needs as well as a good relationship with the family. As Adam finds any change extremely difficult having the same social worker during this time of many changes, helping him and his family prepare and plan for change will hopefully go some way to reducing the anxiety and making the process more positive.

It was identified that Adam was at risk of hospital admission under the Mental Health Act as his anxiety levels had increased which resulted in extremely challenging behaviours. In addition there was a risk of carer breakdown. A Community Education Treatment Review (CETR) was organised. The Transition Social Worker had a pivotal role in ensuring all the professionals whom were involved were invited as well and collating all the reports documentations that were required for the meeting. The CETR identified a wraparound service of support from Health, Education, CAHMS, Social Care Transition service for Adam and his family and the Transition Social worker was the key person to co-ordinate this.

Current situation:
Adam is attending the specialist Behaviour Evaluation Support Team (BEST) two days and nights a week, focus of the work is around managing behaviours. Support from a specialist agency is in place in the home, objective of this is to prevent carer breakdown and support parents in the care of Adam at home. School are providing home schooling with a plan for gradual transition back to school. CAHMS are supporting around managing behaviours, emotions, attachments and medication.

The aim is to prevent Adam being admitted to hospital. Since the support has been in place Adam is now readily going to BEST (he was refusing to leave the house and became extremely distressed) his support in BEST has decreased from 3:1 to 2:1. Adam is engaging in activities. When returning home he is managing short family trips. Adam's sleep has improved.

This is an on-going case whereby the Transition Social worker will remain involved to support Adam and his family through the journey of preparing for adulthood.