# Health/Local Authority Intellectual Disability Transitions Referral Group Terms of Reference (TOR)
# Gateshead Borough

## Purpose

The Health/Local Authority Transitions Group has been formed to ensure that Transitions for those who are 17 ½ yrs. are transitioned in a seamless way. This TOR provides the framework for how health teams , local authority children and adult services for those with an Learning Disability will work together to ensure the best outcomes for all young people with disabilities as they move into adult life.

The purpose also is to stop referral duplication from CYPS, other health teams and Local authority into adult service and so CYPS can discuss with other stakeholders in the meeting on cases they may be waiting support for.

## Frequency

The Health/Local Authority Transitions Group will meet on a three monthly basis to identify and discuss referrals into the Adult Community Learning Disability Team.

## Group Members

Firstly it is important to note, that attendees must be those who are in a position to make decisions on behalf of the service they work in. This will ensure that transition process for the young person is not delayed.

## Representatives

Adult Community Learning Disability Team (Team Manager, clinical lead other nominated representatives as required)

Local Authority Transitions Team (Senior Practitioner or Team Manager or other nominated representatives as required)

Children Young Persons Service (Psychology and/or other nominated representative as required)

Looked after Children and Young People's Team (Team Manager or other nominated representative)

Designated Nurse Looked After Children, Gateshead and Newcastle CCG

## Transitions Timetable (17 yrs. to 18yrs)

Following a young person's seventeenth birthday they will be discussed at each meeting (with their consent or in their best interests) to raise awareness of their

needs. They will be discussed at each meeting thereafter until the referral is activated if required.

If the Health and Local Authority Transition Group agree the criteria for referral to an adult service or services **(see appendixes for service referral criteria's)** are met and the young person has consented or there is a best interest consent decision, then that young person at 17 ¾ will be referred to the appropriate Adult Community service/s.

Any referring service to adult service/s are to ensure that their core records are up to date e.g. Risk assessment/s, initial assessment document/s, medications, care plan, social care assessment of need, Educational Health Care Plan (EHCP).

Such documents where possible and if known, will outline

- Brief medical history.
- Physical health needs
- Behavioural needs
- Mental health needs
- Schooling.
- Epilepsy risk
- Social Activities /Interests.
- Significant Life Events

## 17½ – 18yrs Next Steps

As per Cumbria, Northumberland Tyne and Wear Transition Policy the following steps will take place once a referral is made to adult services.

1. At 17 ½ yrs. where CYPS believe a person under their care with a learning disability will require support at 18yrs and they meet the criteria set by other stakeholders for access to their services, a referral will be made to that adult service.

2. The allocated adult and CYPS practitioner to then meet within 1 month to discuss case further and then arrange two further visits before young person is 18yrs to do joint visit to introduce adult services to the family/carer/service user and to then complete a transition plan (see attached)

3. Psychiatry Medics will refer to each other by letter and CYPS medic will ensure that adult psychiatry are informed of persons medical history and ongoing concerns that will need treatment /review in adulthood when the young person is 17 and 9 months. This allow adult psychiatry time to arrange appointment for when the young person is 18yrs

4. The following information is to be handed to young person/ carer/ family.

   Adult team leaflet
   Information on adult social services
   Local Authority transitions leaflet

5. CYPS have primary responsibility for the service user until the user is 18yrs

6. Before transfer/transition to adult service, CYPS case holder, will ensure all core documentation and other relevant documentation is completed prior to handover

**What are the benefits for family/young person?**

By following the steps 1- 6 outlined above the young person will have

- Integrated holistic care
- Smooth transition from young people's to adult services
- Time to form and build new relationships with other professionals
- The young person and family/carer/s will know who is coordinating the young person's care
- Help to alleviate anxieties around transition for the young person and their family/carer/s

**When the young person requires crisis support when in transitions**

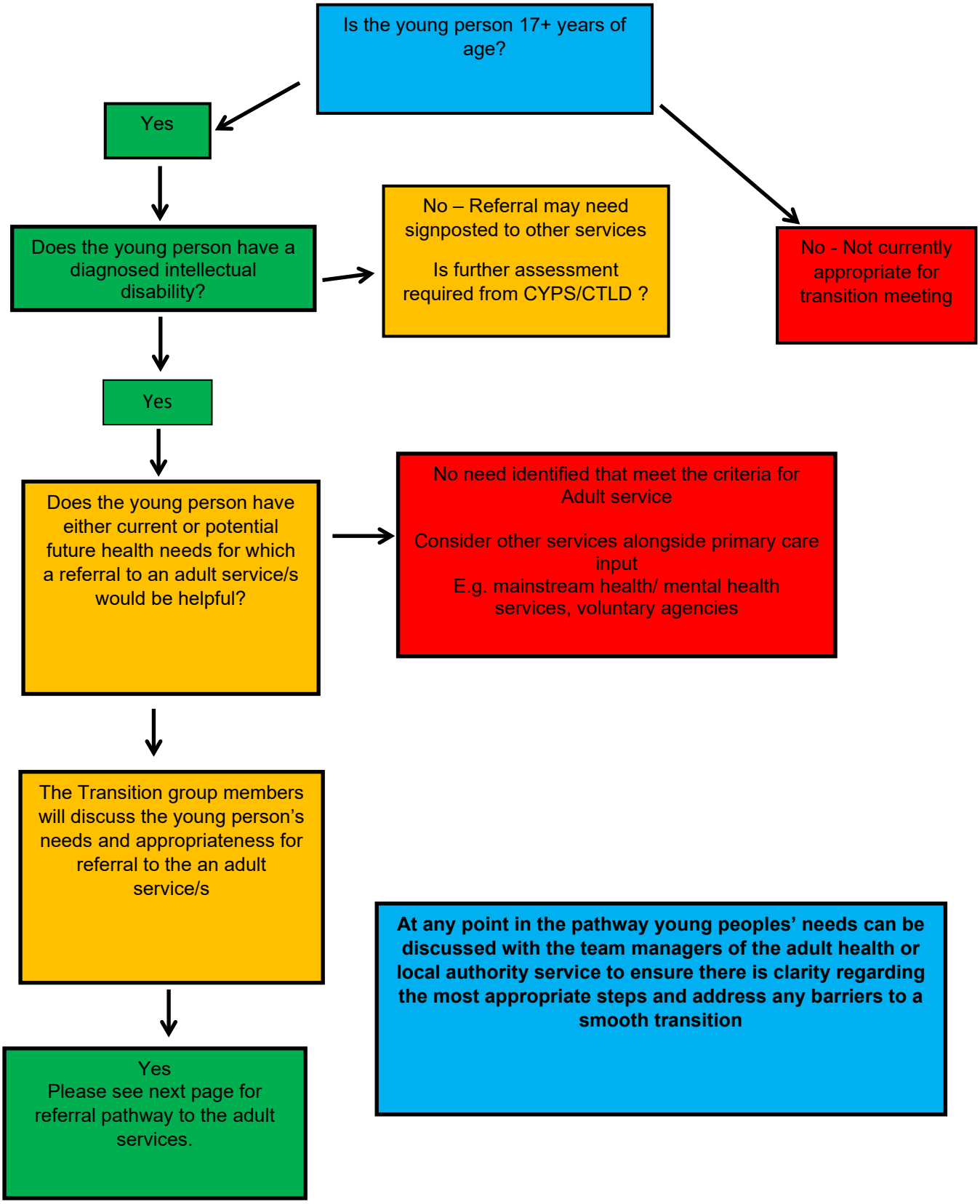
The care of the young person remains the responsibility of CYPS until he person is 18yrs old, therefore any crisis support required whilst the young person is in transition, will be supported by CYPS services and outreach team.

**Learning Disability Screening**

For many young people their Education, Health and Care Plan refers to their 'Intellectual difficulties', this is terminology generally used by Schools and Educational Psychologists who do not provide a diagnostic service.

For those whom it is unclear whether they have an Learning Disability, and uncertainty whether they can access Adult Learning Disability Services, the team can offer an Learning Disability screening. At 17 ¾ they can be added to the Referral list through the group meeting though the young person must also have an associated health need, such as mental health, physical health or behavioural need that cannot be met through enhancement of social care provision or within primary care services.

# Transition meeting pathway for Young People with Learning Disability and /or Additional Health Needs



# Learning Disability Assessment Pathway
# Gateshead Adult Community Learning Disability Team

**Transitions Referrals**

Accepted when 17 3/4 + years of age

Complete ABAS and LDAS (Even when the IQ is already available)

**Referral into the Gateshead Adult Community Learning Disability Team (LD) (Opened by Learning Disability Admin Team)**

There has to be an ongoing clinical need if so Complete referral form
Check if known to LD services via database and RIO

Check consent has been given and that risks have been identified

If the person is not already known to the service then allocate to nurse from hub and to psychology for LD assessment

If the person is known to the service and Learning Disability clear and conformation of diagnosis is given then no further Learning Disability assessment is required

**ABAS, LDAS and WAIS**

Arrange face to face appointment with patient and complete Rio documentation, Consent, LDAS, ABAS and WAIS as required.

LD Team to score assessments and review results

Following Nursing/Psychology assessments are concluded to review with psychiatry to adjust/confirm diagnosis under ICD10 Diagnostic Criteria.

**Considerations/Validity of Assessment**

When there are child protection/ court proceedings try and arrange joint appointment with psychology to complete ABAS and LDAS.

When people have been prescribed long term anti-psychotic medication which may result in cognitive decline.

If there are child safeguarding proceedings a WAIS would not be completed due to ethical issues

If a communication assessment is required then a referral to SALT can be considered

The LD team will communicate the results in the most suitable and personalised way

**Feedback**

If the person does not have an LD

Meet with the person and their carer/ family member

Report and accessible letters distributed (additional copies to GP and psychiatry)

**Feedback**

If the person does have an LD

Meet with the person and their carer/ family member

Report and accessible letters distributed (additional copies to GP and psychiatry)

**Communication Assessment (SALT)**

Make a referral to nursing / other professionals after assessment completed. Arrange feedback session with professionals involved in assessment.

If a person requires a reassessment the referral will be considered on its own merits and if deemed appropriate by the MDT a reassessment will be completed

| | |
|---|---|
| **Clients Name:** | **DOB:** |
| **Rio:** | **Newcastle or Gateshead?** |
| **Dates of Transition Meetings Where Discussed:** | |
| **Has Rio core assessment been updated? Y or N** | **Has FACE Risk been updated recently?** Y or N |
| **Summary of Involvement with CYPS to Date:** | **Current Needs:** (also including any risks, medication, etc.) |
| **Young Person/Family's Views:** | **What do you think they will need post-18 from CTLD?** |
| **Outcome of Transition Meeting:**<br>○ **Bring back to next Transition Meeting**<br>○ **Submit written referral to CTLD**<br>○ **Update Rio Docs**<br>○ **Inform young person/family of plan**<br>○ **Other:** _____<br>○ **Other:** _____<br>○ **Other:** _____ | **My to do list:**<br>○ _____<br>○ _____<br>○ _____<br>○ _____<br>○ _____<br>○ _____<br>○ _____ |
| **Notes:** | |

# Access to the Adult ADHD service from Children Young Peoples Service

Evidence must be clearly documented in Rio that the Child or Young Person's Transition review has been planned in advance with an identified worker.

Referral to the Adult ADHD service will be required with the template provided.

Acceptance criteria

The core documentation MUST be completed and include the justification of diagnosis of ADHD with named professional. The rationale for the commencement / continuing of medication must be benchmarked against NICE guidance.

The client must be stabilised on medication before transfer to Adult ADHD they will not be accepted during titration.

Onward Referrals made to appropriate adult services in advance.

If the documentation is not completed fully and available then Adult ADHD service will not accept the transition of the client.