

### **Identifying good practice and improvements for transition**

A young person in who was looked after by MTCBC and placed in Specialist Residential Care was assessed as part of the transition process. The initial recommendation was that a like for like placement would be required at a cost of over £4,500 per week. By working jointly with our colleagues in CTMUHB, we were able to conduct a high-quality assessment of both his health and social care needs. This allowed us to identify that a less restrictive placement would be suitable at aged 18.

Working with our supported living framework provider, we were able to identify a property which could be used as an additional supported living placement within our area. We also achieved a financial contribution from health in the initial transfer period. Other savings achieved included the cost of transport to education to local provision which was significant because his previous placement was over 15 miles outside the area.

The young person benefited with greater freedom, independence and responsibilities, whilst also living within his own community and close to his support networks. We were able to create three supported living opportunities within our commissioning framework in supported living for less than the cost of the original proposed placement. After an initial settling-in period, health commissioning support was no longer necessary as good quality social care support has shown to be exactly what he needed.

Another young person (although not in transition) was also placed in this supported living placement soon afterwards. The placement as a whole for the two individuals still costs less than the initial costing for a specialist residential placement for the young person in transition alone. Without creating the further vacancy, it is possible that we would not have had any suitable vacancy in our framework providers which would have resulted in another more expensive spot purchase.

A further strength has been the improvement of communication and relationships between adult services and children's services. Strong relationships between team managers have developed, and the Complex Care Senior Social Worker in adult services has also been made available for consultation to colleagues in children's services.

Learning from previous transition cases has been consolidated to inform improvements in the transition business process within the local authority and this has been signed off recently by the Adult Services Leadership Team.