DRAFT

TRANSITION PROTOCOLS

AND PROCEDURES

London Borough of Richmond upon Thames and the Royal Borough of Kingston upon Thames

Introduction

The purpose of this protocol is to ensure that young people who are likely to need additional support with their transition to and support in adulthood have a planned, coordinated and positive progression through the process.

This protocol relates to the period between the age of 14 to 25 with key changes happening at age 16, 18 and 19 for most young people. The document is in two sections; children and young people with additional needs or disabilities and children with mental health issues.

This protocol identifies the expectations for all professionals from; education, social care and health services in both Children's and Adults' Services.

Principles

- Young people including those with disabilities, additional needs, sensory loss, addictions or mental health issues and their parents/carers will have clear information about transition and the options available for their future.
- There will be a seamless and timely planned transition between appropriate services.
- Young people and their parents or carers will be fully involved in the making of all decisions which affect their lives.
- There will be excellent partnership working, information sharing and communication between the young person, their family and all services involved or potentially involved with their care and support.
- The young person's eligibility for services and identification of the most appropriate support will be established at least one year in advance of the transition point.
- Where a complex or significant package of support from health, education or social care services is likely to extend beyond the responsibility of the funding agency, discussion with any receiving agency is required in a timely manner.
- Responsibility for the provision of resources and any existing commitment to funding will be clear and explicit prior to transfer.

Safeguarding

It is the responsibility of everyone to safeguard children and vulnerable adults. Although at the point of transition to adulthood protocols might be different subject to the needs of the individual and their situation. The policies, procedures and lead agencies for safeguarding are defined by age.

The procedures followed for safeguarding children are those set by the Local Children's Safeguarding Board (LSCB).

The procedures followed safeguarding vulnerable adults are those set by the Safeguarding Adults Partnership Board (SAPB).

Table of Process key stages

Up to age 25
An Education Health and Care (EHC) Plan can be requested at anytime.
At annual or emergency interim educational reviews, a request can be made to change provisions or placements if they are not meeting the child's needs.
Annually in Quarter 1
AFC performance and SEN teams share details of children with disabilities or additional needs entering Year 9 to populate the borough specific transition tracking lists.
From age 14
The Transition tracking group will meet a minimum 4 times per year to identify likely support needed with transition, future adult team and specific needs post 18.
Year 9 SEN/ EHC plan review identifies likely support required through transition and the post 16 education provision is first discussed.
If the child is Looked After Personal Education Planning (PEP) starts to focus on transition, where possible the EHC plan and PEP meetings are combined.
If open to Children with Disabilities Team a referral to Moving Forward Transition team to start discussion with family about transition and person centre transition planning
14-19 team start tracking the education pathway for young people and identify young people at risk of being not in education, employment or training (NEET)
Careers advice and discussions about future options is arranged and provided by schools from this point.
Carers are supported to seek support in their own right with their caring responsibilities at this time of change.
From age 15
At the Year 10 education review participants should clarify whether the young person wishes to attend a local college, and whether this local facility can meet his or her needs.
Children aged 15.5 may transfer from the Looked After Team to the Leaving Care Team.
From age 16
Young person meets with the preparation for adulthood worker to discuss their proposed next educational provision. Information fed back to SEN team and tracking group.
Discussion about and visits to potential appropriate next education provisions with support from preparation for adulthood team if required
Families who identify their child will need support with transition into adulthood and support in adulthood will be supported by SPA to identify a lead professional to help them with this.
Children's services complete transition referral form and send it with supporting documents to identified adult team. (SPA lead for young people not open to social care)
Adults services invited to become involved in discussions where decisions might commit them to funding post age 18 or other agreed transition point if different.
If the child is Looked After a Pathway plan will be started to support the young person to think about transition options.
Specialist children's health professionals start to discharge children into the care of specialist adult or community health services from this point.
Children's continuing healthcare nurse completes and sends formal referral for adults NHS continuing care screening to the relevant commissioning support unit.
From age 17
The continuing healthcare checklist is completed by a commissioned provider following the standards and timeline for assessment as identified in the CHC guidelines.
The proposed CHC support plan is presented to CHC funding panel for consideration not later than age 17.5.

Identified adult team complete a contact assessment, if eligible for support the young person will be allocated a social worker or care manager to complete an assessment of their needs.
Young person's personal budget amount will be identified and they will be supported to develop a costed support plan which is taken to adults funding panel.
If panel agrees the proposed plan the provisions will be arranged in preparation for transfer, if not agreed the plan will be reviewed and re-submitted to panel.
On their request carers of young people turning 18 including young carers are referred to adult services for support in their own right.
From age 18 (or transfer date is later date is agreed)
Transfer responsibility from children to adult service, adults service provide funding and support as agreed in the support plan.
New support is reviewed after 6 weeks and then after 3 months then annually to ensure the provisions are meeting the anticipated outcomes, the package is amended if required to reflect changing needs.
NHS continuing healthcare funding and support is delivered as agreed in the CHC checklist and assessment
All EHC plans will be reviewed annually and may only cease when it is agreed that the EHC plan is no longer needed, the local authority is no longer responsible for the young person or at the end of the academic year the young person turns age 25
If the child was Looked After their Personal Education Planning (PEP) and pathway plan are reviewed annually. Where possible the PEP and EHC review meetings should be held jointly.
At age 25
EHC plan should cease at age 25, however it can be maintained until the end of the academic year if the young person turns age 25 before their course has ended.

Transition to adulthood process
(young people and adults with additional needs and disabilities)

This protocol is based on a timeline between the ages of 14 to 25 years, however all young people are different so the timeline may be different for some individuals.

From age 14 (Year 9)

Tracking and assessment

1a The tracking group chaired by the Transition Development Officer in Richmond and the Transition Manager in Kingston will discuss borough specific lists of children collated from information primarily from the Special Educational Needs Team. Any professional can request another young person's name is added to the tracking list. The chairs will update the lists which are saved securely and accessible to only authorised appropriate staff. The lists will only be up datable by the chair and one other in each borough.

2a The tracking group is attended by managers and representatives from children's and adult's health, education and social care services. The group will identify if the young person is likely to need support into adulthood and if so, track progress through transition and identify which should be the lead adult service.

3a The tracking Group will meet a minimum of 4 times per year.

4a Young people unknown to members of the tracking group or whose needs are unclear or disputed, a member of the group will fulfil the designated officer role and gather information to be brought back to the next meeting for discussion. This information will be sourced from the Education, Health and Care plan (EHC)/ transition plan and/ or single assessment or Common Assessment Framework (CAF).

Annual reviews of Education, Health and Care plan (EHC) or statement

5a When a young person has a statement of special educational needs (SEN) or an Education, Health and Care plan (EHC), it is reviewed annually to ensure that it reflects the student's support needs.

6a The local authority is to provide a list of children/young people who will require a review of their EHC Plan that term to all head teachers or principals of colleges at least 2 weeks before the start of each term.

7a Head Teachers and College Principles are responsible for arranging dates for the reviews, and are required to send invitations to relevant health and social care professionals. They will give no less than 2 weeks notice of an annual review.

8a Where children are looked after by the Local Authority, Personal Education Plans (PEP) are required and completed by Children Looked After Team in Children's Services. The PEP should be an integral part of the child's plan and should be used to reflect any existing education plans such as an Individual Education Plan (IEP). Therefore the annual review of SEN / EHC plan and PEP will be held together.

9a A request may be made for written reports, which should be received by the school in time for these to be circulated at least two weeks before the review meeting.

10a Following the review meeting the school or college must send out the report of the meeting within 2 weeks to the young person and their parents, the local authority and anyone else invited to the meeting.

11a Within 4 weeks of the meeting the local authority must decide whether it proposes to keep the EHC plan, amend it or cease to maintain it and notify parents, young person and all concerned.

Preparation and attendance of young people at education reviews

12a The young person's involvement in the planning for their future is essential. Young people should be actively encouraged to participate fully in transition discussions and meetings about their lives. The lead professional and family must consider how best to engage the young person in planning, and to attend their EHC plan review.

13a Involving the right support person is essential to enable people of all abilities to prepare and have their say. This may include the school, family, preparation for adulthood worker, participation worker, other paid professionals, friends or an independent advocate.

Health support and screening

14a For children who receive continuing Health Care (CHC) funding it is the responsibility of their CHC nurse to share information about whether they are likely to need CHC funding into adulthood with the transition tracking group and the relevant Clinical Commissioning Group (CCG).

15a Young people who are looked after have an annual health screening assessment. Social workers should ensure that this has been arranged by referring the young person to the looked after child/ leaving care nurse, or GP. It is important that the last health assessment report is discussed at any review meetings.

16a For young people looked after a long way from their home borough, the social worker must consider who is best placed to complete the health screening, this might include requesting health professionals local to their placement do this.

Children with educated other than at school (including elective home education)

17a Where a young person is educated at home or other than at school the SEN Team will convene the annual review meeting. The child's parents/carers must be invited and the meeting should take place in the most appropriate location such as hospital or the parent's home, and be chaired by a member of the SEN Team.

Transition plan

18a The aim of the annual review in Year 9 and in subsequent years is to review the young person's statement or EHC plan which includes planning for transition to adulthood. Some children may also have a separate person centred plan and/ or PEP

19a The aim of the transition plan is to prepare for all aspects of the young person's transition to adult life including education, health and social care.

Support for Carers including Young Carers

20a Carers are eligible for a carers assessment and there may be other resources and support available to them, including with housing information, carers support and welfare benefits at this time of change.

21a It is the responsibility of the lead professional involved with the young person in transition to speak to their carers about support available to them. The worker should complete a carers assessment or suggest that the carer contact local carers organisations for advice and support at this time.

22a Carers assessments should be reviewed annually.

Service development and monitoring

23a If service gaps are identified during the discussions at the tracking group, in transition planning or though other routes, the Transition Development Officer/ Manager will report them back to the multi-disciplinary Transition Management Group for discussion and to inform commissioning priorities.

From age 15 (Year 10)

Looked after children and Leaving Care

24a At age 15 and a half children who are looked after will be considered for a transfer of their support to the Leaving Care team. A timeline for this transfer will be agreed subject to the young persons' individual needs.

Post 16 education or work options

25a At the Year 10 education review participants should clarify whether the young person wishes to attend a local college, and whether this local facility can meet his or her needs.

26a If the education options are complicated or out of borough there must be an early review in Year 10 to allow time to identify possible placements and to plan the transition.

From age 16 (Year 11)

Identifying support with Transition planning for young people

27a Any families who identify that their young person will need support into adulthood but who are unknown to Specialist Children's Services will be directed to the Single Point of Access team (SPA) to establish if they are eligible for support.

28a Where they are found to be eligible a single assessment will be completed before advice, support or services are considered or offered.

29a Where there is no social care need for the child or family outside of transition the family will be supported to identify a lead professional for support

30a SPA will request that the young person's name is added to the transition tracking list in the appropriate borough.

Post 16 education or work options

31a The EHC and transition plan are considered at the annual review meeting. This is to ensure the young person's plan reflects the most up to date and suitable post 16 options available i.e; apprenticeship, work, health, housing, support, educational placement.

32a If a specialist college is likely to be required, the preparation for adulthood worker will work with the young person, their family, the children's and adults services lead professionals to identify the best provision before sourcing funding within the appropriate timescales from the SEN Panel.

33a If the young person is considering an out of borough education placement and they have a statement of educational need, the preparation for adulthood worker will assist the young person and family to understand the options and if necessary support the family to visit the different placement options.

Specialist children's health professionals

34a Specialist health support for children and young people provided by paediatricians, consultants and specialist children's therapists changes when these professionals discharge the care of children. The decision to discharge and who to discharge care to is led by the health worker holding the case and is based on clinical need. They will identify if a referral on is required and if so at what point this transfer will happen. As this is based on clinical need it will be different for each child.

Looked after children and planning

35a At age 16, children who are looked after will be supported to start pathway planning. This plan will link with any other assessments and plans including the EHC plan to inform the next steps for the young person and their move towards adulthood and successful transition out of care.

Introduction of other new professionals

36a It is important that professionals, young people and families consider whether any new children's or Adult's Services social care, health, education professionals or others should be introduced at this stage. This could include voluntary organisations to support carers as well as the young person with issues such as welfare benefits, housing and support.

Continuing Healthcare Checklist and assessment

37a If a child is receiving Continuing Healthcare funding in children's services a formal referral for adult NHS Continuing Healthcare screening must be made at age 16. This will include sending a copy of the child's most recent assessment to the relevant Clinical Commissioning Group.

Inter-agency working to agree future support and funding options

38a Service and Team Managers responsible for Children's, Education, Health, and Adult Services should attend and present transition cases at funding panels within the appropriate timescales that fit in with the booking timetable of placements, and agree clear responsibilities for each agency including handover dates and funding responsibilities.

Transfer of EHC plan to further education

39a Any child with a statement of educational needs at this transition point who are changing school, will have their statement converted into an EHC plan which will set out the support required for the young person in further education.

Establishing eligibility for adults services

40a If the needs or eligibility of the young person are unclear by the young person's 17th birthday, the transition tracking group can request an assessment is completed by Adult Services to establish the young person's likely eligibility for services.

41a Where the young person has a range of disabilities or is looked after this may be a joint assessment. The involvement of an Adult Service for this assessment does not infer that they are responsible in any way for this client.

42a If the young person is assessed as not likely to be eligible for Adult Services they will be provided with information about adult community resources and referred to the preparation for adulthood team or SPA to identify appropriate support. At any point the young person or their carers can again request a new assessment from Adult Services.

43a If it is considered by children's services that the young person will need support in adulthood but they do not meet the criteria of any Adult Team, discussions at Assistant Director level between children's and adults services will decide the best way forward.

Formal Transition Referral to Adult Services

44a During this year the lead professional in children's services completes and sends the transition referral form (appended) to the adult team identified by the tracking group.

45a The adult team review the referral information and if the young person is identified as eligible in adulthood they will be allocated a Social Worker from the appropriate team.

46a If the referral is not accepted the referrer may need to provide further information.

47a The local authority can decide to continue to provide care and support from Children's Services until the EHC plan is no longer maintained or a decision is made that this is no longer appropriate. The local authority must continue this support until they have reached a conclusion about the need for support from adult services.

From age 17 (Year 12)

Carers including young carers

48a Young carers and Parent carers are entitled to an assessment of their own needs from Adult Services. Where Children's Services are aware of a carer or young carer (turning 18) it is their responsibility to ask if they wish to be referred to adults services.

49a If they do request support the lead professional involved must make the referral or if no-one is involved SPA must identify an appropriate professional to make the referral.

50a If they do request support but no-one is involved, SPA must identify an appropriate professional to make the referral.

Continuing Healthcare assessment process

51a The adults continuing healthcare checklist is completed following the standards and timeline for assessment as identified in the CHC guidelines.

52a The proposed CHC support plan is presented to CHC funding panel for consideration not later than age 17.5 so that provisions can be arranged and in place for when the young person turns 18.

53a Agreed provisions must be planned and ready to start at point of transfer to adults services.

Adult services assessment process

54a If the adult social worker or care manager has not met a young person and their family by their 17 birthday or their Year 12 education review (whichever is sooner), a joint children's and adult service visit must be arranged to start their assessment.

55a The adult assessment identifies the young person's needs and outcomes to be met by Adults Services.

56a The final assessment leads to the identification of an indicative budget amount that Adult Service will provide to meet the young person's identified needs.

57a The young person is then supported to develop a costed support plan that uses the available funds to meet their needs.

58a The costed support plan is sent to the social worker who will then arrange to take it to the funding panel along with any other required paperwork

59a If agreed at panel the services as identified in the support plan will be arranged ready to be implemented when the young person turns 18 (or agreed point of transfer if different)

Funding and funding options

60a If the package of support includes funding from a combination of Health, Education and or Social Care all aspects of the package must be shared with each of the panels for clarity.

From age 18 (Year 13)

Transfer to Adult Services

61a On the young person's 18th birthday case responsibility moves to the identified Adult Service, where this timescale is not appropriate to the child another date can be agreed.

62a For young people looked-after transfer may be at age 18 or for the leaving care team may continue to provide support and services up to 21 (or 25 where the young person is in education). Where transfer is not at age 18 there may be joint working agreements put in place between Adults and Children's services.

63a In exceptional circumstances to allow continuity of service, Children's services may agree to continue to provide or fund a provision past the young person's agreed transfer date. This continued funding may be recouped from the Adult Service or remain the responsibility of Children's Services subject to the agreement.

From age 19 (Year 14)

64a **Monitoring and review of support**

65a The support a person receives from adult social care, or continuing healthcare is reviewed annually.

66a EHC plan reviews are held annually and where appropriate these reviews should be combined with social and health reviews and must have all relevant professionals involved.

67a If a young person returns to education, they can request an EHC plan up until their 25th birthday.

68a EHC plans should cease at age 25, however they can be maintained until the end of the academic year a young person turns age 25. It is important that a child or young person's exit from an EHC plan is smooth and planned.

Transition to adulthood process
(young people and adults needing specialist mental health services support)

Referrals to Child and Adolescent Mental Health Services (CAMHS)

1b New referrals to CAMHS (Tier 3) or emotional health services (Tier 2) may be made via the local SPA from any professional providing the family resides in and/or is registered with a GP in the borough.

2b If the referral is deemed appropriate the CAMHS team will offer a first appointment within 11 weeks unless it is an emergency in which case the young person will be seen within 48 hours. A treatment plan will be drawn up with the young person and family and further intervention will be offered if appropriate.

Transition from CAMHS to adult mental health services

3b The Transition Co-ordinator will liaise regularly with mental heath service managers to track the young people who receive or may need their services.

4b For young people receiving a service from CAMHS their transfer to the Adult Community Mental Health Team (CMHT) follows the protocol below. This has been agreed by South West London and St George's Mental Health NHS Trust.

Young people receiving care from CAMHS

5b Where young people are receiving a service from CAMHS and will require on-going mental health care, the care coordinator for CAMHS should commence discussion with Adult Community Mental Health Service (CMHS) at the review prior to the young person's 18th birthday. The transfer of care arrangements must be explicitly agreed in writing.

6b When CAMHS are providing time-limited interventions, these may continue beyond the 18th birthday in consensus with the Adult CMHT.

CAMHS discharge 14+

7b Young people discharged from CAMHS aged 14+ must have on their record a summary of their diagnosis, chronology of interventions and success's in the form of an exit or gateway assessment to inform future interventions in the event that further support is required.

New referrals aged 17-18 years old

8b Referrals of young people between 17 years of age and up to their 18th birthday should be assessed in the first instance by the CAMHS team. Where required the duty psychiatrist will assess out of hours and make an onwards referral to the CAMHS team.

9b Where a young person aged 17+ is assessed as having a severe mental illness and requiring enhanced Care Plan Approach (CPA) it may be appropriate for CAMHS to arrange for treatment to commence with the Adult CMHT.

10b Where a young person is assessed as having a severe mental illness and requires in-patient admission, a referral to the CAMHS Tier 4 in-patient service will be made by CAMHS Tier 3.

11b Where a young person is assessed as having a severe mental illness and requires intensive input from CAMHS without an inpatient bed, a Referral to the Adolescent Outreach Team Tier 4 will be made by CAMHS Tier 3.

Young people aged 17+ if admitted to an adult mental health bed

12b As South West London and St Georges Mental Health Trust has its own inpatient service based at Springfield Hospital, it is unlikely that the young people will be admitted to an adult mental health bed. However on the rare occasion this is necessary that they will:

13b Where the young person is assessed as having a severe mental illness requiring enhanced CPA, arrangements for the transfer of care to the adult service should commence at the point of admission. Until the transfer arrangements have been agreed with the Responsible Medical officer (RMO) responsibility rests with CAMHS. This happens very rarely as the tier 4 Aquarius Unit usually admits these vulnerable young people.

14b Where the mental illness is transient and less severe the young person's care will transfer temporarily for in-patient treatment to the appropriate Adult CMHT consultant, adult acute wards. Care should transfer to the appropriate CAMHS team on discharge and arrangements for transfer to the appropriate Adult CMHT will commence if necessary.

Young people referred to CMHT aged under 25 years old

15b If a person is between 18 and 25 years of age at the time of referral to the CMHT they must contact CAMHS to ascertain whether there has been any previous involvement. If CAMHS was involved the nature and outcome of this must be shared with the respective CMHT.

16b CMHT to inform the tracking group of any new referrals for support of young people up to age 25 years.

Transfers to and from CAMHS Early Intervention Service

17b Patients under 18 years of age with a first onset psychosis who are considered to require mental health services will be the responsibility of CAMHS who will need to make arrangements for admission to hospital or other facilities as required. The immediate responsibility on admission would be the same as those outlined above.

18b Patients aged 18 and over with first onset psychosis who are considered to require mental health services will be the responsibility of the CMHT. This team remains the single point of access to the adult service but the person may be referred to the EIS.

19b The appropriate service for patients aged between 17 and 18 will be considered on an individual basis in consultation between the CMHT, CAMHS and EIS.

Transfers to and from the Adolescent Assertive Outreach Service

20b The principles of this protocol apply to transfers from CAMHS teams to the Adolescent Assertive Outreach Team and onto Adult Services at 18 years of age.

Documentation Associated with Transfer of Care

21b All transfers of care must include an up to date Risk Assessment, Relapse and Risk Management Plan and Enhanced Health and Social Care Plan in accordance with the Trust's Policy 'Care Programme Approach, Care Management and Risk Assessment and Management'. The referring team retains responsibility for providing and coordinating care until the transfer has been effected. No case will be closed without the involvement of all relevant agencies in the decision making process.

Arbitration

22b All transfer of care arrangements should be agreed locally by the appropriate teams. In exceptional circumstances where there is a disagreement about the point at which care should transfer, Clinical Team Leaders should involve the appropriate Clinical Leads and Directors if necessary.

Other relevant reading and guidance

Continuing Health Care
This guidance sets out the principles and processes of the National Framework for NHS Continuing Health Care and NHS funded nursing care.
https://www.gov.uk/government/publications/national-framework-for-nhs-continuing-healthcare-and-nhs-funded-nursing-care

The Care Act 2014
The core purpose of adult care and support is to help people to achieve the outcomes that matter to them in their life. This guidance document sets out how a local authority should go about performing its care and support responsibilities for adults care and their unpaid carers.
https://www.gov.uk/government/publications/care-act-2014-statutory-guidance-for-implementation

The Care and Support (Eligibility Criteria) Regulations 2014
This is the national minimum eligibility which describes the criteria for adults who need care and support.
http://www.legislation.gov.uk/ukdsi/2014/9780111124185/pdfs/ukdsi_9780111124185_en.pdf

Children and Families Act 2014
A summary of the main changes and provision of the Act and how they might effect children.
https://www.gov.uk/government/publications/young-persons-guide-to-the-children-and-families-act-2014

Special Educational Needs and Disability Reforms
The new Children and Families Act describes how services will be continuous to age 25 and brings together education, health and care professionals to work with young people and families to identify the support needs and appropriate provisions for children.
https://www.gov.uk/schools-colleges-childrens-services/special-educational-needs-disabilities

SEND in Richmond and local offer
http://www.richmond.gov.uk/about_send

SEND in Kingston and local offer
http://www.kingston.gov.uk/info/200326/special_educational_needs_and_disability_send

Special Education Needs Code of Practice
Guidance on the special educational needs and disability (SEND) system for children and young people aged 0 to 25, from 1 September 2014.
https://www.gov.uk/government/publications/send-code-of-practice-0-to-25

Looked After Children and Leaving Care guidance
These regulations and guidance are designed to ensure care leavers are given the same level of care and support that their peers would expect from a reasonable parent and to give them the opportunities and chances needed to help them move successfully in to adulthood.
https://www.gov.uk/government/publications/children-act-1989-transition-to-adulthood-for-care-leavers

Mental Health
This document published in 2014 sets out 25 priorities for change. It details how changes in local service planning and delivery will make a difference to the lives of people with mental health problems in the next 2 or 3 years.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281250/Closing_the_gap_V2_-_17_Feb_2014.pdf

Transition
This helpful government website is all about preparing for adulthood. It has useful information and resources for young people, families and professionals.
http://www.preparingforadulthood.org.uk/who-we-are