



TELFORD & WREKIN MULTI AGENCY TRANSITION PROTOCOL

A JOURNEY TO ADULTHOOD

Children & Young Peoples Plan – Our vision;

“We will make a positive difference to the lives of all children, young people and their families in Telford & Wrekin, by putting their needs and views at the centre of everything we do...”

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1. INTRODUCTION

All young people between the ages of 14 and 25 experience major changes in their lives with the journey from childhood to adulthood; the move from being a pupil to an employee and from dependence on parental care to independence in the community. This can be particularly challenging for vulnerable young people and their families, including those leaving care or those affected by disability or illness.

The Children and Young People's Plan is the Commissioning Strategy of the Children's Trust Board developed to meet the priority needs of the population of children and young who are the responsibility of Telford and Wrekin. The Children's Trust has identified a need to improve the transition arrangements for children and young people in the Borough and therefore adopted this as a particular priority in 2010.

2. PURPOSE

This protocol sets out the expectations, roles and responsibilities of all agencies that support children and young people through transition from childhood to adulthood. It should therefore be used to ensure that a multi agency, person centered approach is adopted to make an effective contribution to the transition planning processes and achieve the goals identified by children and young people in the Borough.

3. SCOPE

This protocol encompasses transition arrangements for young people aged 14 – 25 years with SEN, Learning Disabilities; Physical Impairments; Sensory Impairments; Social, Emotional and Behavioural Difficulties and/or complex Health Conditions, ASD, and those who are in the youth justice system and Children in Care.

The protocol sets out the need for age specific interventions from young people's services in readiness into adult services and the support to be provided from adult services

4. PRINCIPLES

- Keeping the needs of children and young people central to planning,
- Working positively together to improve quality and outcomes,
- Young people and their carers/parents should be fully involved in the making of all decisions which affect their lives.
- Transition should be seamless for children and young people
- Information should be readily available and accessible
- Responsibility for care management, provision of resources and any funding implications must be clear and explicit at all times

- Age related interventions meet young peoples needs throughout their journey into adulthood
- Ensuring the curriculum offer provided in school and in post 16 providers matches the needs of the child or young person
- Provide learning opportunities that develop and promote greater levels of independence and autonomy

5. LEGISLATION AND STRATEGIC CONTEXT

A range of legislation underpins the transition process for young people with additional, complex and special education needs.

- Disability Discrimination Act 1995
- Education Act 1996
- Education (Special Education Needs)(England) (Consolidation) Regulations S12001/3455 substantially amended by SI 2006/3346
- SEN Code of Practice 2001 (DfES)
- Children Act 1989 and 2004
- NHS & Community Care Act 1990
- Learning & Skills Act 2000
- Health and Social care Act 2001
- Valuing People: A new strategy for Learning Disability for the 21st Century, 2001
- And Valuing People Now 2008 (DH)
- Fair Access to Care Services
- Social Exclusions Unit (2005) Transitions. Young People with Complex needs ODPM
- Healthy Lives, brighter futures 2008
- Every Child Matters: Change for Children
- The White Paper “Care Matters: Time for Change” 2007 (DfES)
- Learning & Skills Act, 200 S139a (all young people with SEB who are likely to go on to education and training must have a Section 139a assessment)
- Education and Inspection Act 2006 (*duty to commission positive activities for “vulnerable” groups of young people*)
- Mental Health Act 1983
- The Children (Leaving Care) Act 2000
- Apprenticeship, Skills, Children and Learning (ASCL) Act 2009 (53-57) 16-18 transport duty
- Working together to Safeguard children; A guide to interagency working to safeguard and promote the welfare of children, 2010

6. TELFORD & WREKIN LOCAL POLICIES AND STRATEGIES

- Policy for the Inclusion of pupils with special educational needs 2004
- Adults with Learning Disabilities Strategy 2008 – 2011

- Transition Policy – Child & adolescent mental Health services to adult services
- Children with Disabilities Strategy 2008 – 2011
- Mental Health and Well-Being Strategy 2008
- People and Places: Telford & Wrekin Housing Strategy 2010 – 2013
- Homelessness Strategy 2007
- Housing, Care & Support Strategy
- Joint Protocol for the Assessment of Housing and Support Needs of Homeless 16/17 Year Olds (and Carers).
- 16-18 Transport Policy

7. GUIDANCE & RESEARCH

- What Makes a Successful Transition from Primary to Secondary School? (DCSF RR019 2008)
- National Framework for NHS Continuing Healthcare and NHS funded Nursing care
- A Transition Guide for all services; key information for professionals about the transition process for disabled young people (DH/DSCF 2007)
- Transition: Moving on Well 2008 (DH/DOH)
- National Framework for Children and Young People’s Continuing Care (DH 2010)

8. INFORMATION TO SUPPORT THE PROTOCOL

Needs data and performance Information will be collected from the various agencies involved in transition support to inform strategic planning and improve transition services.

Transition information will be gathered together centrally and used to inform future commissioning and planning, seeking to ensure Value for Money for all stakeholders.

9. PERFORMANCE MONITORING AND REVIEW

The implementation of this Protocol will be the responsibility of all agencies identified in the document. It will be overseen and reviewed by the Telford & Wrekin Strategic Transition Group, a multi agency partnership representing the agencies, children and young people and parents and carers of the vulnerable young people who require support through transition.

The Telford & Wrekin Strategic Transition group will develop and agree a performance monitoring framework focussed on outcomes that support service improvements in transition and report on this by exception to the Health & Wellbeing Partnership Board and Children’s Trust Board.

10. COMPLAINTS FROM CHILDREN AND YOUNG PEOPLE AND THEIR PARENTS/CARERS

Anyone who receives services in relation to this protocol has the right to make a complaint or other comment or representation, and to have it dealt with under the complaints procedures of the relevant agencies or schools.

When a complaint is upheld the investigating organisation will give due consideration to the dissemination of learning and outcomes to ensure similar situations are avoided in the future.

11. DISAGEEMENT RESOLUTION ACROSS AGENCIES

Any disputes in relation to the operation of this protocol should be dealt with through negotiation by all parties involved and should, where possible be resolved before the young person in need reaches the age of 18 years old or transfers to adult services.

12. INFORMATION AND INFORMATION SHARING

The principle of informed consent will underpin the sharing of data about young people.

Clear and accessible information about all aspects of transition will be made available in a range of formats at a time most useful to the young person, parents and carers and the young person will be offered a copy of any transition plan

13. AGENCIES SIGNED UP TO THIS PROTOCOL

CVS

CVS provide the Parent Partnership Service to the Borough and will:

- arrange for the parents of any child in their area with SEN to be provided with advice and information about matters relating to those needs;
- to take such steps as it considers appropriate for making services known to:
 - the parents of children in their area;
 - the head teachers and proprietors of schools in their area;
 - such other persons they consider appropriate.

Local Authority: Connexions4youth

Connexions4youth (c4y) must be involved in the year 9 review and take a lead in progressing the transition plans and carry out Section 139a assessment for young people with learning difficulties and disabilities and will provide information advice and guidance up to the age of 25 years,

Local Authority: 14 – 19 team

Will facilitate the provision of suitable and appropriate educational/vocational provision and learning support for young people 16 – 25 with learning difficulties and disabilities as part of the Council's statutory duty. Will fund provision at independent Specialist Providers (ISP's) where no suitable local provision or support is available to meet a learners needs.

Local Authority: SEN team

Will enable all young people with a SEN to reach their full potential and make a successful transition to adulthood by working with the schools to follow the SEN code of practice and offering advice, guidance and support to support families of children and young people with a Statement.

Local Authority: Housing

Homeless PA's will support 16 and 17 year olds who are homeless or identified via assessment as at risk of homelessness and conduct a joint assessment with an officer from housing services to present to the young persons housing pathway panel.

Local Authority and NHS: Adult social care and mental health and substance misuse services

Will support young people in need in transition to adult services and carrying out adult community care assessments leading to the provision of a care plan. The responsibility for care where assessed as appropriate will take effect from 18 years but the adult services will commence work with the young person when they are 16 to facilitate smooth transition and identify a lead worker to implement the transition to adults services.

Local Authority: PCP & Transition Team

Will engage with young people with learning disabilities from 14 years through transition to adulthood via a person centered plan and work closely with all agencies involved with the young person, particularly the special schools, social care and health and will take on any care management responsibilities when they are 17 ½. The team will support the young person to produce a Person Centred Plan (PCP) following the transition team processed map (Appendix 2). The PCP should be completed by the first review following the young person's 17th Birthday. The Person Centred Plan should be revisited as the young person moves through transition and into adulthood. Young people on the Autistic Spectrum may be assessed by the ASD worker based in the transition team when they are aged 17 ½ in relation to the eligibility for adult social care services.

Local Authority & NHS: Children and young people's integrated disabled children's services (including specialist health services)

The social work team will attend year 9 transition reviews and subsequent reviews for all young people who are on the caseload of the team. They encourage the development of independence and will transfer the responsibility to adults social care services at 18 years.

The community specialist health teams will either attend transition reviews or provide the necessary information to complete a young persons' transition plan from a health perspective and will ensure a smooth transition between pediatric services and adult medical services.

Local Authority School SENCO (Special educational needs coordinator)

The SENCO (special needs coordinator) is the school teacher with the responsibility for the planning of the special educational provision within a school. The school will prepare young people for the process of transition through Personal Social and Health Education (PSHE) and draw up a Transition Plan during the annual review in Year 9 as set out in the SEN code of practice and support the young person to realise their educational achievement potential.

NHS CAMHS and Adult Mental Health services

There is an operational CAMHS transition protocol between the two services (Appendix 3) which will be followed to [provide a seamless transition to adult services. This includes identification at 15 years old anyone likely to need transition into adult services.

NHS CHC Team (adults)

Will screen young people for consideration for NHS Continuing Health Care and if appropriate assess for eligibility to NHS Continuing Health Care or NHS-funded nursing, so that if eligible a suitable care package can be arranged for their 18th Birthday

Post 16 Education and Training providers

To support the young person to realise their educational/vocational potential and goals identified in their transition plan by planning and delivering and appropriate curriculum and learning support.

Local Authority: Children's Social Care Teams (children in care)

If the young person is looked after (child in care) the Person Centered Plan should link with the requirement to produce a Pathway Plan and the lead taken

by the Pathway Co-ordinator. This should happen at the young person's first review after their 16th birthday. Social workers should attend year 9 reviews

The Children & Young Persons Social Worker will close the file providing a transfer summary to Adult Services at 18 years

Schools and Academies

Will meet their statutory education requirements and provide young people with opportunities to gain accreditation and provide options and careers advice e.g. work experience, college placements, travel to learn.

Sensory Inclusion Service (SIS)

Will support young people with visual and hearing impairments to maximise their potential and independence as they move towards adulthood.

Short Breaks Service Providers and Youth leisure provision

Will support young people to access adult sports and leisure provision and promote independent living skills

Transport

The Local Authority has a statutory duty in respect of arrangements for young people (over compulsory school) aged 16-18 and those continuing learners who started their programme of learning before their 19th birthday to ensure access to education or training for learners of sixth form age. A learner with learning difficulties and/or disabilities may take longer to complete a programme of learning or training, and therefore the Local Authority may extend the arrangements for the provision of transport until a learner has completed their programme even if that is after they have reached the age of 19.

Youth Offending services - YOS

The YOS will support young people through the period when they come out of custody to deliver on their resettlement plan until the end of the Order.

14. FINANCIAL ARRANGEMENTS

Through transition planning processes no agency will agree to any support packages/interventions unless they have authority to fund under their budget authority arrangements or have prior agreement by the budget holder.

14.1 Benefits

It is the responsibility of Children's services social workers to offer all disabled young people a benefits review at the age of 16 years.

14.2 Joint Solutions

The children and young people's joint solutions panel operates to identify and commission appropriate packages of care and agree funding from multi agency sources for children and young people up to 18 years of age.

14.3 Transfer of financial responsibility between children and adults services

Children's social care budgets will fund all care provision for children up to their 18th birthday. The young person and their family/carers must be advised as part of the review that to access adult community care service's people's needs will be assessed against FACS (Fair Access to Care Services) to see if those are eligible needs. If eligible then the adults Fairer Charging Policy will apply from the young person's 18th birthday and informed in a straightforward manner what this means in terms of changes to service delivery. At the first review meeting following the young person's 17th birthday they and their family/carers should be informed in writing of the implications of the charging policy for the provision of community care services on the person's 18th birthday.

Children and adults services will work together to ensure that young people and their families are fully aware of the differences of service provision and possible eligibility for services once they reach 18, how they will differ from children's services and that some services will no longer be available. Workers must help young people and their families to plan for such changes.

14.4 Continuing Health Care

The Continuing Health Care Team will assess for eligibility to NHS Continuing Health Care or NHS-funded nursing and commission and fund appropriate packages of care for adults.

15. Transition Panel

A multi agency transition panel will identify and monitor young people in transition and resolve individual cases where particular complexities exist. The terms of reference for the panel are under review at the time of drafting this Protocol.

THE TRANSITION PATHWAY

The transition pathway in the table below outlines the transition process from planning to review and implementation set out by year group. It details who has responsibility for the relevant transition task. Each agency is expected to undertake the tasks that are set out for them and work with the young person, their parents/carers and other agencies to agree and review the transition plan each year. Individual and interdepartmental transition operational procedures will underpin the pathway and the relevant agencies will pursue transition pathway arrangements agreed with the young person and follow through on lifeskills training and other transition developmental areas identified in individual transition plans.

Through the transition process the views of the young person involved should be sought and recorded wherever possible. Where possible the young person should be supported by school, Connexions4youth an advocate or parents to prepare for the review meeting. The Council's Transition team will actively support young people with learning disabilities to produce a person centred transition plan in an accessible format.

Special Arrangements:

Children in Care

Children & Young People's Services will retain the Local Authority duty under The Leaving care Act which came into effect on the 1st October 2001.

The Local Authority has a duty towards eligible and relevant and former relevant children:

Eligible: Are those Young People in care aged 16 and 17 who have been looked after for (a total of) at least 13 weeks from the age of 14.

Relevant: Are Young People aged 16 and 17 who have already left care, and who were looked after for (a total of) at least 13 weeks from the age of 14, and have been looked after at some time while 16 or 17.

Former: Are Young People aged 18-21 who have been **eligible** and/or **relevant** Children In Care – Young people who are looked after by a Local Authority either through a compulsory Care Order or remand or accommodated by voluntary agreement including accommodation under section 20 of the Children Act

Local Authorities duties under the Leaving Care Act

Aged 16 – 18 years

- Duty to ensure a pathway plan is in place by 16th Birthday
- Duty to make an assessment and meet needs

- Duty to provide financial support.
- Duty to provide a Personal Advisor

Aged 18 – 21

- Duty to maintain contact and to provide support the a Personal advisor
- Duty to assist with costs of education, employment and training.

Aged 21 and over

- Duty to 18-21 year olds if still in education or training
- Duty to ensure vocational accommodation for higher education

The last Local authority to Look After a Young Person is the Local Authority responsible for meeting the duties under the Leaving Care Act wherever the Young person may be living in England or Wales

Local Authorities have a duty to assist former relevant children until the Young Person has completed the programme of education and training agreed with the responsible Local Authority

Financial support under the Leaving of Care act includes the cost of:

- Accommodation
- Food and domestic
- Pocket money
- Transport cost for education and training
- Clothing
- Childcare costs

YOUNG PERSON WITH A STATEMENT EDUCATED OTHERWISE THAN AT SCHOOL OR OUT OF BOROUGH

When a young person is educated otherwise than at school the general transition pathway and arrangements for the annual review in year 9 will remain the same as for pupils in schools and the Councils SEN department will convene the review meeting. However, the transition process may also need to involve consideration of wider issues i.e. the view of the child's doctor may be sought due to major health difficulties; if a child has been excluded then the views of the tutor or other professionals should be sought; when a young person is educated at home then the SEN team will need to work closely with parents to ensure that all appropriate professionals attend the review meeting.

Where the young person is placed or educated out of Borough then the Connexions team in the Host authority will support the young person through the transition process with the local social care team if appropriate. Our local SEN team will attend reviews for out of borough placements.

YOUNG PEOPLE IN THE YOUTH JUSTICE SYSTEM

Young people that are part in the youth justice system will have a resettlement plan which will identify their needs in relation to transition back into the community and the relevant support networks. These will be lead by the Youth Offending service and Connexions4 youth will play the same part in those plans as identified in the pathway below. The resettlement plan which considers all aspects of living in the community (accommodation, health, independent living skills, EET, substance misuse etc) will be delivered by the YOS until the end of the order followed by a TAC.

TRANSITION ACTIONS	WHO IS RESPONSIBLE?
Year 8 12 – 13 yrs	
Identify the young people who have statements and those who on are School Action and School Action Plus. Information to be discussed with the Connexions4youth Personal Advisor.	SENCO and C4Y Personal Advisor (PA)
Connexions4youth, Health & Social Care to be informed of statemented young people, including primary reason for SEN	SEN Team/SENCO
Preparation for year 9 Transition Review meeting is carried out. Start to work with the young person to explain the transition process. Good practice for these to be integrated with other statutory reviews (with permission of family)	PA
Young persons participation and communications needs to be identified, Link with tutors, parents/carers, speech and language specialists	School/Connexions4youth PA with appropriate specialists e.g. speech and language
Begin moving forward plan (Section139a)	PA/SENCO
Year 9 13 – 14 yrs	
<p>Cyp and their families are given an Information Pack about Transition. The transition pack explains the role of Connexions; adult and consumer care services; cyp integrated services; general information and guidance (this information pack is currently under review for updating).</p> <p>Meet the cyp identified for transition with SEN either individually or in a group to introduce Connexions4youth, their role and the transition process</p> <p>Complete “your views” with the young person and record on CAF if required and begin moving forward plan (section 139a)</p>	<p>Connexions4youth Transition Team (cyp with learning disabilities)</p> <p>Connexions PA</p> <p>Connections PA</p>

TRANSITION ACTIONS	WHO IS RESPONSIBLE?
(Children's Social workers should identify and attend the year 9 reviews of young people who are eligible for assessment under section 5 of the disabled persons act 1986)	Children's social worker is are involved at this point and the transition team will attend if the yp attend special schools or placed out of Borough and the yp has a learning disability and will meet the criteria for adult services.
Identification of all those young people who are in receipt of services and likely to require assessment for adult social care and support services. (The Council must under section 5 of the disabled persons services consultation and representation act 1986 establish whether a young person with a statement is disabled and may require services from the local authority on leaving school.)	SENCO/PA/CHILDREN'S SOCIAL CARE/TRANSITION TEAM
SENCO or PA to telephone the ISM to check on Protocol and ecaf to identify other services involved and the lead professions. Lead professional to attend the transition meeting.	SENCO/PA
Adult teams to be informed where there is a strong possibility of significant input / funding packages from age 18 (see children's continuing care guidance Appendix 1 in respect of NHS Continuing Health Care)	PA/TRANSITION TEAM/CHILDREN'S SOCIAL CARE TEAMS
Transition review is arranged to review statement and draw up transition plan	SENCO/PA
<p>Invitees to year 9 review are made:</p> <ul style="list-style-type: none"> • The young person (should always be invited even if decides not to attend) • The young person's parents or guardian • Relevant teacher – class tutor or SENCO • Lead professional from children's services (clusters or social care services and any health services involved with the young person) • Any person the head teacher considers appropriate • Connexions4youth PA • Advocacy service if required <p>All young people who have a learning disability should be offered a health action plan (valuing People) The transition team coordinate health action plans, GP practice nurses complete health action plans on request,.</p>	SENCO/PA

TRANSITION ACTIONS	WHO IS RESPONSIBLE?
Year 10 14 – 15 yrs	
<p>Preparation for year 10 review meeting is carried out Annual review of transition plan takes place to include. Check on progress, consideration of appropriate post 16 opportunities/options available.</p> <p>Review of health needs</p> <p>Relevant adult services team informed where strong possibility of significant input/funding packages from age 18</p> <p>Good practice for these to be integrated with other statutory reviews with permission of young person and family</p> <p>Notification to Post 16 team if specialist education and training provision is needed post 16 or if support needs are significant</p>	<p>The school is responsible for arranging the review of statement and transition plan. PA to offer advice and guidance Senco and PA to oversee delivery of the transition plan</p> <p>The health lead professional will review the health transition plan for the yp and include in the transition plan</p> <p>PCT commissioners team notify cases to NHS continuing Health Care team as appropriate in Appendix 1 (cyp CCC guidance)</p> <p>Post 16 team to capture potential high cost cases on planning sheet for following years budget.</p>
<p>A transition review meeting will be held - potential complex needs may be identified. Actions and who takes ownership of each action are agreed and the transition plan is Updated. Person centered planning underpins the process.</p>	<p>To be attended by School / PA and other relevant professionals including member of transition team who is leading if yp with LD or the Host Connexions PA where the YP is educated out of area.</p>
<p>identify which young people with statements likely to leave school at end of year 11 and disabled.</p>	<p>PA</p>
<p>Health professionals including paediatricians (and their associated teams) should begin to introduce the concept of transition long before it becomes an issue. As part of this programme, the doctor should introduce the concept early so that the young person could be seen by themselves in clinic visits or with someone of their own choice, with parents invited to join the session later.</p> <p>Consider information transfer, Young people with long term conditions often have bulky medical records – it can take several hours to produce a multidisciplinary summary of their history and management in a way that will be useful to someone taking over their care. Paediatric teams should liaise with adult teams to ask what information is most useful. Giving young people copies of key letters and summaries to keep in a personal health record, health passports and ensuring that GP's are kept</p>	<p>Paediatric consultants/SALT/phsyio/CCN</p>

TRANSITION ACTIONS	WHO IS RESPONSIBLE?
fully informed	
Year 11 15 – 16 yrs	
Encourage attendance at open days/evenings and IAG/transition Journey events.	School/PA/Transition Team
<p>Complete the Moving Forward Plan (s139a) if the yp is leaving school after yr 11 and collate future education provider information pack Send 139a assessment to Post 16 team 139a Assessment completed Sept – Dec led by Connexions Jan - March 139Aa shared with local providers for assessment April- Aug 139a considered by post 16 team and funding package agreed with partners contributions where appropriate.</p>	<p>PA & SENCO Connexions Post 16 Team</p>
Arrangement of Year 11 transition review and transition plan. Relevant agencies informed of annual review dates including the post – 16 provider. If already identified, good practice to integrate with other statutory reviews with permission of young person and family	School/PA
Attendance at yr 11 review. Annual review of transition plan takes place, to include as appropriate: check on progress, choices & goals/applications or funding applications, transition to college / employment/ day services/, benefit checks, consideration of long term care needs and health needs.	All lead professionals involved
For children who do not have a statement of SEN discussion should take place between parents and representatives from the agencies to decide if the child should have a formal transition plan drawn up (school action/school action plus)	SENCO/PA
Named Worker. For young people to whom this protocol applies and who are between the ages of 16 and 18 years old there will be a named Children & Young People's Service worker and a named Adult Services worker.	Respective Social Care teams to identify named worker.
For cyp in receipt of Camhs then their case should be flagged up via the 6 monthly camhs multi agency liaison meetings as per the Camhs transition policy happen. CAMHS clinician identifies need for ongoing support of young person beyond age 18	<p>CAMHS Team Manager refers to;</p> <ul style="list-style-type: none"> - CMHT Manager and/or - Early Psychosis Team Manager - ALD Manager <p>Adult team allocates a Care Coordinator</p>

TRANSITION ACTIONS	WHO IS RESPONSIBLE?
partners contributions where appropriate.	Post 16 team
<p>Young person should be in process of transferring from paediatric to adult health services, depending on needs and readiness.</p> <p>Set up a preparation period and education programme for the young person and parent: identification of the necessary skill set to enable the young person to function in the adult clinics.</p>	Health professionals involved with the young person
<p>When a cyp is 17 and an assessment for consideration for eligibility to NHS CHC is required then the Protocol in Appendix 1 Protocol will be followed and screening will be commenced.</p> <p>If eligible the young person will receive health services commissioned by the CHC as appropriate at 18 years</p>	<p>NHS CHC Team</p> <p>NHS CHC team</p>
<p>The lead responsibility for young people in receipt of social care services will shift from Children & Young People's Services to Adult Services 6 months before the young persons 18th birthday or at another time agreed as part of the transition plan. Children and Young People's Service workers will however remain involved with the young person until the age of 18 years old or otherwise agreed as part of the planning process. Lead responsibility for the co-ordination of care is different from lead responsibility for funding.</p>	Named workers in children's/adults social care
Year 14	
Where yp has LD continue to work with young person family school and transition team to identify and refer suitable post 19 education provision if appropriate	Connexions PA/transition team
Post-School to 25	
IAG support will be provided to young people with disabilities up to the age of 25	Connexions4youth
Young people receiving palliative care hospice services from Hope House will continue to receive these until they are 25 years old	Hope House
Sharing of information on young people who have had 139a assessments up to aged 25 to ensure statutory duty has been met and evaluate quality, value for money and effectiveness of provision and support.	

Appendix 1: Transition Years – Consideration For NHS Continuing Health Care & NHS-Funded Nursing Care

Principles

Transition planning for children from aged 14 to 18 should identify C&YP who should be screened for consideration for NHS Continuing Health Care and if appropriate assessed for eligibility to NHS Continuing Health Care or NHS-funded nursing, so that if eligible a suitable care package can be arranged for their 18th Birthday.

Cyp Continuing Care is not the same as NHS Continuing Health Care (NHSCHC). Cyp Continuing Care is a multi-agency response to children with complex disabilities who need enhanced intervention support to universal and mainstream services. NHS Continuing Health Care is about adults with complex health care needs who if eligible to NHSCHC would have their care arranged and funded by the NHS. NHS-funded nursing is an NHS contribution for adults placed in a registered care home providing nursing.

Table 1 identifies the time scales, triggers and the care professional who should identify cyp who may need screening for NHS CHC and notify their agency lead manager responsible for the transitions protocol.

Agency lead managers for transitions policy are:

- CAMHS (tier 3 or 4) – CAMHS manager
- Cyp Community Nursing and Paediatric Hospital Discharge – Cyp CN manager
- Cyp with a cyp Continuing Care enhanced intervention support package – Lead Joint Commissioner
- Cyp in Care who may need a registered care home providing nursing at aged 18 – Cyp LA Placement Team
- Adult Services - refer to the Transitions Protocol regarding the involvement of adult services in transition planning

The agency lead manager will notify the NHS Continuing Health Care Team manager of cyp who may need to be screened.

The NHS CHC team will contact the care professional initiating the referral to consider the screening tool and next steps.

When the cyp is 17 and an assessment for consideration for eligibility to NHS CHC is required the NHSCHC team will:

- Request resent and current assessment / care plan records from multi-agency assessments and the health professional assessments and Transition Officer involved in the cyp care and seek clarification if required. These records will provide the evidence to inform consideration of the persons provisional eligibility to CHC
- initiate the assessment drawing on multi-agency and multi-disciplinary assessments
- provide the cyp / family with information on NHSCHC process, seek their consent, and inform them and the lead professional of the outcome
- notify the initiating professional and the lead manager for transitions of the outcome
- if provisional eligible to NHSCHC is confirmed they will commission a suitable care package for the person for their 18th birthday.

Where provisional eligible to NHSCHC is confirmed the cyp NHS Lead Officer and their Agency lead manager for transitions will raise the case at the Transitions Panel and follow transition protocol procedures for the hand over of the care plan to an Adult Health Services Lead Officer.

Where the cyp is not eligible for NHSCHC and their needs change the referring professional should discuss the case with the NHS CHC team to consider the screening tool and next steps, which may include if appropriate a reassessment for consideration for eligibility to CHC.

Children's and Young People Transitions Process for Consideration for NHS Continuing Health Care from Aged 18

Aged 14 -15 Education year 9 /10	Age16 Education year 11	Age 17 Education year 12	Age18 Education year 13
PCT: Lead Joint Commissioner notify NHS Continuing Health Care Team to help inform strategic planning	Lead Officer role - Identify CYP who should be considered by the NHS Continuing Health Care Team for eligibility to Continuing Health Care or Funded Nursing Care. Lead Officer for each trigger: Lead Joint Commissioner – Trigger 1 CYP NHS Specialist lead Health Professional – Trigger 2 Lead Social Worker via the Cyp Placement Team – Trigger 3 CAMHS ROS – Trigger 4 Cyp CNS - Trigger 6 & Trigger 5		
Trigger The CYP has an approved cypCC package of additional support to universal and specialist health care	Triggers – The cyp aged 16 - 17 1. has an approved cypCC package of additional support to universal and specialist health care 2. has multiple health care needs which are unstable, unpredictable, intense, frequent and complex receiving specialist and universal health services and screening against the cypCC care domains indicates the CYP level of health need is high in 3 domains or severe or priority in one domain. OR at aged 17 3. may be placed in a registered care home providing nursing 4. has a long term placement in a MH/LD hospital, meets the trigger in 2 above and planning for discharge has commenced prior to aged 18 5. has Fast Track Care in the 3 months prior to aged 18 6. Cyp in hospital, meets the criteria in trigger 2 and planning for discharge has commenced prior to aged 18		
NHSCHC Team - Checklist screening to establish if the CYP should be considered for NHS Continuing Health Care for adults and inform CYP / Parent and referrer of the outcome.			

Principles

- CYP and Families need an understanding of respective responsibilities of the NHS, social care and education and how these differ in Children's and adult services.
- Transition process should be consistent with the *Telford & Wrekin Transition Protocol*
- The Transition Health Action Plan should incorporate the NHSCHC process where triggers indicate it is appropriate

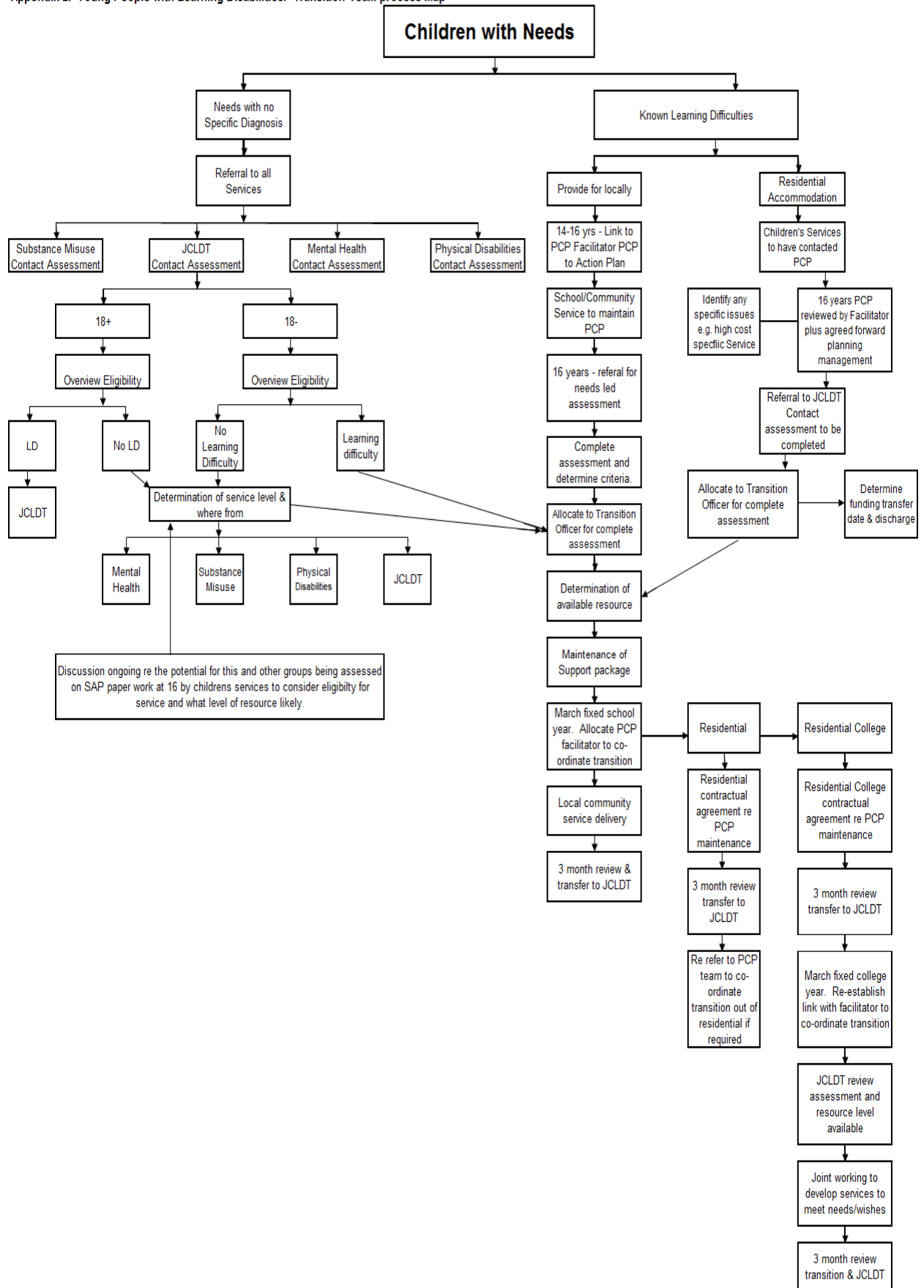
Abbreviations
 CYP – Children and young people
 cypCC – Children and Young People's Continuing Care
 CAMHS ROS – Child & adolescent mental health reaching out service
 Cyp CNS – cyp Community Nursing Service
 LA – Local authority
 LD – Learning disability
 MH – Mental health
 NHS CHC – National Health Service Continuing Health Care (adults)

NHS Continuing Health Care determination assessment
 The responsible commissioning NHS CHC Team – draws on MDT health plans and other assessments developed as part of the transition process.

The responsible NHS Continuing Health Care Panel
 Responsibility: determine eligibility to NHS Continuing Health Care in principle and communicate decision to CYP/Adult lead professional, the CYP /Parent and GP

If Eligible to NHS Continuing Health Care PCTs
 Commission effective Package of care in time for 18th birthday
CYP & Adult Lead Health Professional transfer of care plan to ensure appropriate adult universal and specialist services are in place at aged 18

Appendix 2: Young People with Learning Disabilities: Transition Team process map



Appendix 3: Camhs Transition Policy

Document Title:	Transition Policy - Child & Adolescent MH Services to Adult Mental Health Services or to Adult Learning Disability Services.		
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Document Overseeing Group:	Partnership Policy Committee		
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Transition Agreement – Mental Health

1. Transition to adulthood

- 1.1 “The transition to adulthood is a graded process and variable according to different individuals' rate of maturation and development. It is important that cut-off points between child and adolescent mental health services are not applied too rigidly.

Flexibility of service to meet therapeutic need is always desirable.

We are glad to see reference to a standard age limit (of 18) for CAMHS; and mention of protocols governing the interface with adult services. Commissioners have a key role here in ensuring that protocols are adequate. For example, it must not be possible for a young person, a potential patient to be denied a place on the adult waiting list because he or she is not yet 18, and also denied a place on the CAMHS waiting list because he or she turns 18 before receiving a service. Commissioners should also ensure that protocols and funding arrangements do not require a change of therapist at 18 when this is inappropriate. Flexibility of practice to meet therapeutic need is always desirable.

Lastly it is important that adult mental health services are able to deal appropriately with the remaining transitional and developmental issues after age 18. “

Young Minds response to Children’s NSF Emerging Findings, 2003.

- 1.2 Any conflict or disagreement will be resolved using this policy and ensuring that the needs of the child or young person is always paramount. In rare exceptions, the Head of Child & Adolescent Mental Health and the respective Clinical Director of Adult Mental Health or Learning Disability Services will intervene and agree the best way forward.
- 1.3 The destruction of records policies for younger people will be in accordance with Dept of Health guidelines; this should take into account the need for ALD and AMH services requirements for the history to be available.

2. This agreement applies to:

- 2.1 Adult /Community Mental Health Teams (CMHT)
- 2.2 Early Intervention in Psychosis teams (EIP)
- 2.3 Joint Commissioners of both Children’s and Adult’s Services.
- 2.4 Child and Adolescent Mental Health Services (CAMHS)
- 2.5 Child and Adolescent Mental Health Services- Learning Disability (CAMHS-LD)
- 2.6 Adult Learning Disability Teams (ALD)

3. It recognises the significant contribution of other agencies, not least Social Care, 16+ (Telford & Wrekin) and Care Leavers (Shropshire County) Teams, Housing providers, and 16+ Education and support agencies including Connexions, Learning Skills Council and Youth Offending Services.
4. Shared Principles and roles of commissioners and providers are explained in the overarching Transition protocol.
5. The Agreement describes the detailed procedure to be followed when the young person has ongoing mental health needs.
6. **Forward Planning & Liaison meetings for Team Managers and Commissioners to identify future service requirements** - please refer to table under point 7.

7.

Step	Action
One	Liaison meetings held at 6 monthly intervals in each PCT/LA area will include; <ul style="list-style-type: none"> - CAMHS Team Manager - CMHT Manager - EIP Manager - CAMHS – LD Manager - ALD Manager - Children’s and Adult Joint Commissioners - Others as deemed necessary, e.g. Team Manager of 16+ or Care Leavers, Team, School/College representative, Learning Skills Council, Connexions, Substance Misuse, Housing Managers.

Two	<p>Liaison agenda will include all young people aged 15 and above who are likely to require ongoing support post 18.</p> <p>Particularly crucial to identify young people who are funded in Special Placements by PCT/Joint Protocol arrangements, who will need ongoing financial commitment from Adult commissioners, and/or Housing providers; Plus those who may be eligible for Continuing Health Care.</p>
	Liaison group will not pre-empt or duplicate detailed case planning for individual young people, but will ensure all cases are 'flagged up' to inform commissioners.
Three	Group will develop a strategic overview of all the young people known to be coming through into Adult Services, and help set priorities for both providers/commissioners.
Four	Where the eligibility criteria for CMHT provision or Continuing Health Care support is not met, the group may need to consider what recommendations can be made to partner agencies, and what support mental health services may be able to offer through consultancy arrangements.
Five	The group will review all the young people in the cohort at each liaison meeting, building on the 'Knowledge Management' of potential future service users.

8. Individual Case procedure – please refer to table under point 9.

9.

Step	Action
One	<p>CAMHS clinician identifies need for ongoing support of young person beyond age 18.</p> <p>CAMHS team assessment indicates whether support will include medical or non medical services or both.</p>
Two	<p>CAMHS Team Manager refers to;</p> <ul style="list-style-type: none"> - CMHT Manager and/or - Early Psychosis Team Manager - ALD Manager
Three	Adult team allocates a Care Coordinator and opens an Integrated Mental Health Casefile (IMHCF)
Four	<p>CAMHS worker convenes planning meeting for Care Coordinator, EPT and partner agencies as relevant.</p> <p>Unless strong contraindications, the young person and their parents/carers should be invited to this meeting.</p>
Five	<p>Care plan agreed to include details of:-</p> <ul style="list-style-type: none"> a) co-working agreements or division of responsibilities. b) at what stage formal transfer of medical responsibility should take place c) precise arrangements to review the Transition Plan.
Six	Care plan is implemented and reviewed as agreed at regular intervals until case transfer has been completed and CAMHS withdraw.
Seven	If planning meeting concludes there is no requirement for transition to Adult Services, the CAMHS worker will continue to support young person until case can be closed.

	Closure summaries should provide a succinct report of CAMHS involvement so that if the young person is later referred to Adult services information can be accessible.
Eight	If a young person is referred to Adult Services having been previously known to, and closed by CAMHS the above procedure may need to be instigated, to determine the most appropriate team/clinicians to become involved.

10. Young People, crisis, 24 hour cover and assessment under Mental Health Legislation

11. The NSF for Children, Young People and Maternity Services puts clear responsibilities on commissioners and providers of both CAMHS and Adult Services to ensure both design and capacity of services for young people in crisis improves.

12. For now, the following framework clarifies current procedures – please refer to table under point 13.

13.

Step	Action – office hours	Action – out-of-office hours
One	<p>Young People with urgent mental health needs may present to any agency.</p> <p>Professionals will complete initial assessment, and refer to CAMHS or CMHT.</p> <p>Referrals requiring statutory Mental Health Assessment will be passed immediately to the Approved Social Worker located in the CMHTs.</p>	<p>Young People with urgent mental health needs may present to a range of agencies during out-of-office hours. E.g.</p> <ul style="list-style-type: none"> - Emergency Duty Social Workers, - Police, - General Practitioners and - Other primary health care professionals and community workers. <p>Professionals working in these agencies will make an initial assessment of the young person's needs and make an appropriate referral to specialist services if required.</p>
Two	<p>If the young person is known to CAMHS, the CAMHS key worker will accompany the ASW involved.</p> <p>If the young person is not known, CAMHS may still be able to offer support – or advise CMHT about other appropriate professionals known to the young person, e.g. Personal Advisor for a Care Leaver.</p>	<p>Currently specialist out-of hours services include a 'virtual' team comprising:</p> <ul style="list-style-type: none"> - Approved Social Worker - Assertive outreach staff - CMHT Psychiatrist 'on call' - CAMHS psychiatrist 'on call' <p>For all referrals of young people, the 'virtual' team will collaborate to decide, on the information available at the time, how best to assess and deal with the individual's immediate needs.</p>
Three	<p>The CAMHS worker will provide specialist knowledge and advice and will take responsibility in conjunction with the Responsible Medical Officer (RMO) for finding a suitable inpatient facility should the assessment lead to the young person being detained under the Mental Health Act.</p>	<p>Any placement provided in the emergency will be formally reviewed by the CMHT and/or CAMHS Team Managers on the following working day.</p>
Four	<p>Ongoing responsibilities will be agreed through liaison between Team Managers.</p>	<p>Ongoing responsibilities will be agreed through liaison between Team Managers.</p>

GLOSSARY

CIC (CHILDREN IN CARE)

Young people who are looked after by a Local Authority either through a compulsory Care Order or remand or accommodated by voluntary agreement including accommodation under section 20 of the Children Act

Connexions4youth

Connexions4youth are a services for all young people between the ages of 13 – 19. The provide information, advice, guidance and practical heal in preparing for adult life and work. The Connexions4youth PA is a personal advisor.

ECAF

Electronic common assessment framework which is a key part of delivering frontline services that are integrated and focussed around the needs of children and young people. The CAF is a standardised approach to conducting an assessment of a child's additional needs and deciding how those needs should be met.

Fair Access to Care

This is the Department of Health's guidance to Local Authorities on how to achieve fair access to care services through use of eligibility criteria for adult social care. It is based on the evaluation of individuals assessed needs and the likely risks, both immediate needs and needs which are likely ro worsen for the lack of timely help.

Health Action Plan

A health action plan shows the actions needed to keep a person healthy. It is a way of lining the person to a range of services that will help them to have better health. Health action plans form part of a persons Person Centred Plan.

Pathway Plan

The Children Leaving Care Act 200 requires a Pathway plan for all eligible relevant and formerly relevant young people. The Pathway Plan assesses the young person's needs and planning of any services.

Parent Partnership

Parent Partnership is a service that gives impartial and confidential support to parent and carers

<http://parentpartnership-shropshireandtelford.org.uk>

Person Centred Plan

An individualised plan for young people with learning disability outlining what a young person wants to achieve in the suture and what support and services they will need.

<http://www.telford.gov.uk/downloads/TWC-HSCTransitionPathway.pdf>

SEN
Special Education Needs

SENCO
Special Education Needs Coordinator who have responsibility for managing the effective delivery of the education psychology service, learning support. Behaviour support SEN assessment and administration and parent support.

SECTION 139a

An assessment made by Conexions4youth under the Learning & Skills Act 2000 to make arrangements for the assessment of young people with learning difficulties and disabilities when they are undertaking or are likely to undertake post-16 education or training or higher education.

Transition Plan

A transition plan is a document that outlines what a young person wants to achieve in the future and what support and services they will need to live as independently as possible.